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ABSTRACT

The 1993 recommendations to the Secretary of Health and Human Services on migrant health emphasize that all available federal and state public service programs be mobilized to also serve farmworkers, and that coordination of efforts among federal agencies and departments take place. The following recommendations offer approaches to secure inclusion of farmworkers in programs designed to assure the safety and health of all Americans: (1) an Interagency Memorandum of Agreement among federal agencies that supports expanded appropriations for construction and subsidy of farmworker housing; (2) an annual appropriation of $100 million for the Migrant Health Program for FY 1994; (3) integration of the mental health needs of farmworkers with the services of all federally funded mental health programs; (4) inclusion of specific farmworker components in special projects designed to strengthen the family; (5) inclusion of farmworkers in health care reform such as reciprocity of Medicaid, national health insurance, provisions for mental health care, and expansion of primary services; (6) expanding community outreach services to farmworkers, including hiring bilingual staff and providing training on maternal and child health to migrant women; (7) establishment of an interagency group to address the enforcement of regulations and laws protecting farmworker health and safety; (8) collaboration of migrant education and Department of Labor programs to train migrant youth in allied and clinical health professions; and (9) research on health status indicators of farmworkers by sex and age. (KS)

ED 364 366

1993 RECOMMENDATIONS

OF THE NATIONAL ADVISORY COUNCIL ON MIGRANT HEALTH

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1993 RECOMMENDATIONS

OF THE NATIONAL ADVISORY COUNCIL ON MIGRANT HEALTH

MAY 1993

National Advisory Council on Migrant Health
Bureau of Primary Health Care
Parklawn Bldg., Room 7A-55
5600 Fishers Lane
Rockville, MD 20857
(301) 443-1153

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NATIONAL ADVISORY COUNCIL ON MIGRANT HEALTH

MEMBERSHIP ROSTER

Alaníz, Gilberto
Director, Special Projects
Yakima Valley Opportunities
Industrialization Center
815 Fruitvale Blvd.
Yakima, WA 98902
(509) 457-2930

Duran, David (Chairperson)
Hispanic/Migrant Liaison
State of Wisconsin, DHSS
Division of Economic Support
1 West Wilson Street, Rm. 339
P.O. Box 7935
Madison, WI 53707
(608) 267-9202

Duran, Juan
701 West Lake Street
Crystal City, TX 78539
(512) 374-3722

Duran, Antonio E. (Executive Secretary)
Director, Migrant Health Program
Bureau of Primary Health Care
Parklawn Building, Room 7A-55
5600 Fishers Lane
Rockville, MD 20857
(301) 443-1153

Filoxsian, Hazel
Executive Director
Migrant and Immigration Assistance Center
431 North 22nd Street
Fort Pierce, FL 34950
(407) 464-0705

Garrison, William
High Hope Orchard
308 Crest Road
East Flat Rock, NC 28726
(703) 693-7840

Gutierrez, Manuel de Anda
Human Services Assistant
Department of Human Resources
Children Services Division
910 Pacific Avenue, Suite 500
Hood River, OR 97031
(503) 386-2962

Lockett, Pauline P.
700 S.W. 8th Street
Belle Glade, FL 33430
(407) 996-6559

Lucero, Ricardo
Executive Director
Sunrise Community Health Center
1028 5th Avenue
P.O. Box 1870
Greeley, CO 80632
(303) 356-6014

Martinez, Zoila
P.O. Box 50965
Fort Myers, FL 33905
(813) 334-0956

Merla, Olga
1805 Barcelona Avenue
Harlingen, TX 78550
(512) 428-3385

Ordonez, Margarita
613 O'Banion Road
Yuba City, CA 95991
(916) 674-3702

Pelham-Harris, Patricia
Medical Director
Ogelthorpe Family Medical Center
250 West Main Street
Crawford, GA 30630
(404) 743-8171

Rivera, Angel L.
RR 2, Box 5111
Cidra, PR 00926
(809) 739-8813

Sandoval, Salvador, Jr., MD
Merced Family Centers, Inc.
727 West Childs Avenue
Merced, CA 95341
(209) 723-5823

Viveros, Arcadio
Chief Executive Officer
United Health Centers of
San Joaquin Valley, Inc.
650 Zediker Avenue
Parlier, CA 93648
(209) 646-6618

Migrant Health Program Staff

Antonio E. Duran
Director

Egan, Jack
Deputy Director

Kavanagh, Helen
Policy Analyst and Staff Support, Executive Committee

Puente, Ana Maria
Policy Analyst and Staff Support, Family Issues Subcommittee

Suzuki, Nami
Policy Analyst and Staff Support, National Leadership Subcommittee

Torres, Rosa
Branch Secretary

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Executive Summary

The recommendations are built upon the foundation of prior years' recommendations, testimony which has been presented to the Council, and ensuing deliberations within the council. A bibliography and comprehensive background statements have been developed to further expand upon each recommendation. ***Inherent in each recommendation are the following assumptions:***

ASSUMPTIONS

- Farmworkers are an employed working class contributing to the economies of the communities in which they live and work. They are members of America's working poor.

- Migrant and seasonal farmworkers as a population are no more and no less deserving of the right of access to "safety net" programs than any other group of Americans.

- Their low level of access to health services is due in part to the system's failure to accommodate a migratory work pattern.

- Farmworkers are not to blame for that lack of access; rather, they are a casualty of the system's lack of flexibility.

Nowhere is their dilemma better exemplified than in the administrative practices of the Medicaid program, which cannot accommodate a population which moves from state to state.

The Council also contends that it was not the intent of Congress that the PHS 329 Migrant Health Program meet all of the health needs of this population; rather, these funds should be used in conjunction with all other federal and state public service programs in order to assure the safety and health of farmworkers. ***Therefore, we enlist the Secretary's response in order to assure that:***

FOCUS OF ACTION

- All currently available resources are mobilized to also serve farmworkers.

- Migrant-cognizant representation is included in all facets of the Department's activities.

- The Department assumes the responsibility and provides the leadership for coordination of efforts among all other federal agencies and departments.

In 1988, the Migrant Health Program was re-authorized to include specific language regarding case management. Case management requires the thorough planning and coordination of services and treatment to assure that a patient's complex health needs are addressed and met. If individual components of the problem are addressed in isolation from the others, the health of the patient may not improve. Case management must occur at the local level, with the patient the direct recipient of the service. However, it must also occur at a national policy level, between agencies and departments whose efforts must also be coordinated to positively affect issues as complex as farmworker health. The Council hereby solicits the Secretary's advocacy at the cabinet level in order to create such a national "case-managed" approach to interagency planning on behalf of farmworkers.

RECOMMENDATIONS

The following recommendations have been developed as practical approaches to secure inclusion of farmworkers in programs which are designed to assure the safety and health of all Americans.

1. Housing

Recognizing that the lack of housing for farmworkers creates a serious problem which is currently of crisis proportions, the Council recommends that the Secretary participate in an Interagency Memorandum of Agreement between HHS, HUD, USDA, and FmHA, and support expanded appropriations for construction and Section 8 subsidy of farmworker housing. Specific numbers of newly constructed housing should be targeted at not less than 10,000 units per year for the next ten years.

2. Appropriations/Re-Authorization

Current migrant health funding reflects an annual expenditure of approximately $100 per user per year, and a penetration rate of approximately 12 percent. If PHS 329 dollars are to be the primary source of health care for farmworkers, that appropriation must be increased in order to reflect a commitment of resources more in keeping with expenditures for other populations. The Council recommends an annual appropriation of $100 million for the Migrant Health Program and comprehensive perinatal care services for F.Y. 1994,

with incremental increases thereafter, and requests the Secretary's support of this targeted increase.

3. Mental Health

Farmworkers are desperately in need of access to mental health and family counseling services. They are less able to access existing community mental health services than many populations due to their constant mobility and the unavailability of culturally sensitive and bilingual mental health professionals. The Council recommends that the current state of crisis in the farmworker family be recognized by the Secretary, and opposes further programmatic cuts. Efforts must be initiated to fully integrate the mental health needs of farmworkers with the services of all federally-funded mental health programs. Special focus should be placed on expanded recruitment of minorities in mental health professions, recognition of peer counselors as an effective means of intervention, and service delivery collaboration between migrant health centers and the community mental health program.

4. Family Issues

The Council strongly recommends that all special projects which are designed to strengthen the family include a specific farmworker component in order to assure relevancy to the migrant family. The Council recognizes women to be the central core of farmworker families, and requests that the Secretary's focus upon women and families be expanded to include farmworker women. Special consideration should be made within HHS at the national and state levels to integrate Migrant Health and Migrant Day Care through prioritization of funding for joint service delivery models. More daycare facilities need to be established in farmworker labor camps and communities. The council requests that the Secretary address this as a first step in meeting the needs of migrant families.

5. Health Reform

The Council recognizes that managed care and managed competition are potentially effective cost control measures, but is concerned that these measures could create even greater barriers for farmworkers. The Secretary must assure that farmworkers are not left out of any health care reform strategies. The Council recommends that the Secretary support a program which would standardize eligibility criteria from state to state, provide portable

benefits, and annualize income thus eliminating barriers to enrollment of farmworkers. Any new reform in the current system must not exempt farmworkers and agricultural employers from required protections currently available to other workers. It is essential that the current level of primary care services available to farmworkers not be reduced, and consideration of additional measures should include:

- Reciprocity of Medicaid
- National health insurance
- A separate national Migrant Health Alliance (Health Insurance Purchasing Cooperative or HIPC)
- Provisions for mental health care
- Expansion of primary services to the entire population (at current levels only 12% are served).

6. Outreach

Farmworkers, by the nature of their work and lifestyle, are an extremely hard-to-reach population. Conventional strategies to provide health care services have been less than effective. The Council recommends that the Secretary designate resources to expand community outreach services to farmworkers. All new federal initiatives should include a migrant component and a special allocation for this population, thereby making health care more available, accessible, and acceptable. Use of both clinical and lay health workers has been proven to be an effective and appropriate means of providing services to migrant farmworkers.

7. Occupational and Environmental Health

Farmworkers suffer the highest work related injury (morbidity) and mortality rate in the nation. Agriculture is consistently listed as one of the three most dangerous occupations in the nation. The Council recommends that the Secretary establish an interagency group with the Department of Labor, the Occupational Safety and Health Administration, and the Social Security Administration to address the enforcement of regulations and laws protecting farmworker health and safety (e.g., workers compensation, disability qualifica-

tion, worker protection standards, pesticide exposure, adult and child labor, and field sanitation). The group should be charged with the responsibility to identify and implement joint solutions to assure that farmworkers are able to participate in the programs operated by these agencies, and that legislative and regulatory loopholes which exempt agricultural workers from basic protections available to other workers are eliminated.

8. Health Professions

It is critical that solutions for health professions training for migrant and community health centers be multi-disciplinary and both short and long range in nature. By this we mean that efforts should focus not only upon physicians, but also upon nurses, dentists, hygienists, environmentalists, social workers, nutritionists, etc., since the delivery of care to migrant populations requires a team approach. Solutions to yield immediate results for the health professional shortage must be put in place, as well as long range solutions. Specifically, the Council recommends that the Secretary implement programs which will:

- Collaborate with Migrant Education and Department of Labor programs to train migrant youth in allied and clinical health professions.
- Expand loan repayment programs to include the full range of health professionals, especially nurses.
- Require health professional schools to recruit minority students into the health professions.
- Increase the number of registered nurses in rural areas.
- Encourage advancement of clinic farmworker staff, and the integration of farmworkers into health professions.
- Provide incentives for health professions training programs to offer more opportunities for training in migrant health programs, including formal linkages with these programs.
- Increase recruitment and retention of minority, Spanish-speaking, and/or culturally sensitive health professionals.

- Place emphasis upon training and placement of dental professionals.

- Address the current acute problem in recruitment and retention by appropriation of dollars to enable migrant health centers to offer competitive salaries.

- Establish creative, effective ways for health centers to provide incentive packages which improve retention of providers in all health professions.

- Consider allocation of specific levels of National Health Service Corps dollars for loans and scholarships to be incorporated into funding for migrant health centers.

9. Research

Anecdotal information has highlighted various aspects of the hardships of migrant health and lifestyle. However, the lack of national research and hard data on migrant and seasonal farmworkers has hindered the efforts of clinicians, administrators, policy makers, and researchers to effectively make changes and establish priorities for migrant health. Specifically, estimates of the size of the migrant and seasonal farmworker population vary widely. Basic health status indicators such as age-related death rates are unknown. Prevalence rates of the most common causes of death in the U.S. have yet to be studied. The Council recommends that the Secretary make an overall commitment on behalf of the Department to obtain health status indicators on farmworkers by sex and age by 1994, and on various farmworker sub-populations by 1998. This will require the commitment of non-service delivery funds to conduct research, assess effective intervention strategies, and evaluate policy impact. The Council recommends that the Secretary identify research dollars already allocated by Congress to be dedicated to migrant research efforts, and that every effort be made to secure resources from the Agency for Health Care Policy Research, the National Institutes of Health, and the Centers for Disease Control and Prevention for the same purpose.

HOUSING

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HOUSING

RECOMMENDATION: Recognizing that the lack of housing for farmworkers creates a serious problem which is currently of crisis proportions, the Council recommends that the Secretary participate in an Interagency Memorandum of Agreement between HHS, HUD, USDA, and FmHA, and support expanded appropriations for construction and Section 8 subsidy of farmworker housing. Specific numbers of newly constructed housing should be targeted at not less than 10,000 units per year for the next ten years.

Migrant farmworkers are temporary residents of the communities in which they work. They provide the temporary, seasonally intensive labor that large-scale and diverse agriculture requires in order to produce crops. The communities that use the labor of migrant farmworkers cannot support permanent work forces large enough to bring their crops in due to the seasonal nature of crop production. Growers depend on the large supply of intermittent labor provided by farmworkers, and the workers depend on the income from their labor. Each would suffer in the absence of the other.

Migrant farmworkers sometimes travel singly, but frequently are accompanied by their families, many of whom also work in the fields. The need of the migrant farmworker population for temporary housing during the peak crop harvesting and packaging seasons has traditionally been met by growers in the form of labor camps.[1,2]

Labor camps have always fallen short of the ideal. A U.S. Department of Agriculture Handbook published in 1970 stipulates that the basic requirements of housing for migrant farmworkers include well-built houses made of materials appropriate to their uses, with adequate lighting and ventilation, access to safe water, and adequate space for the number of people inhabiting each house. The handbook also suggests landscaping the grounds and providing recreation areas and child care facilities. A study of actual migrant farm laborer housing undertaken on behalf of the Department of Health, Education, and Welfare in 1978 revealed a prevalence of housing that was overcrowded, unsanitary, and unsafe, and that sometimes failed to even shelter the occupants from the elements.[2]

The housing sampled in the study ran the gamut from wholly uninhabitable to in need of repair. Of the camps sampled, 53.5 percent required repair and 5.6 percent required replacement. 71.8 percent were judged sound, while 26.8 percent were deemed deteriorated and hazardous. The average number of rooms in a single family dwelling was between one and 2.6, with the average

dimensions of rooms being 10'x12' to 12'x15'. Indoor running water was available in only 64.8 percent of the camps, and 21.1 percent relied on privies for raw sewage disposal, while an additional 7 percent resorted to a combination of privies and portable toilets to meet this need. Two thirds of the units lacked any kind of heating system, although they were located in latitudes where heating was necessary. Only about a third of the units possessed interior hygienic facilities. Most of the facilities were inadequately ventilated and did not meet fire escape standards, having only one exit. Bedrooms usually lacked the capacity for the number of individuals housed in each unit, and laundry facilities were generally unavailable. Farmworker Estevan Sanchez described the predicament farmworkers face: "Well, when a farmworker arrives he arrives to the field, and the persons don't just give housing for one person. [There are] three or four people in one single cabin, or we should say maybe in one room."[14] In a large number of units kitchens doubled as sleeping quarters. Of the kitchens surveyed, half had no sink, a quarter had no refrigerator, and 60 percent had improperly vented stoves. Central bathroom facilities often lacked privacy partitions between toilets and frequently did not provide enough toilets to be accessible to the number of workers on site. Barracks-type units designed to house large numbers of single men scored even worse, with 28.8 percent of the shelters not providing basic protection from the elements, and over 50 percent of the barracks not providing heat. The barracks were found to be overcrowded, and no two-story barracks building managed to meet fire escape standards. Even facilities that were licensed, and therefore presumably monitored, showed evidence of fly and mosquito breeding, rodent harborage, and trash burning as well as broken windows, torn screens, damaged steps, roofs, foundations and shells. Sanitation in the form of garbage storage and sewage disposal was found to be inadequate.[2]

The health implications of these housing conditions are alarming. Cold, damp interiors are associated with an increased incidence of otitis and respiratory infections, which occur more frequently among farmworkers than in the general population.[3] The presence of a toilet in a sleeping area is associated with an increased incidence of gastrointestinal distress, anorexia, and gastroenteritis. Substandard and unheated rooms are associated with an increased incidence of measles and upper respiratory infections. Single-bed usage by families is associated with an increased incidence of impetigo and emotional distress. Multi-use sleeping rooms are associated with an increased incidence of bronchiectasis, disseminated tuberculosis, influenza, and tonsillitis. The lack of laundry

and hygienic facilities leads to bathing and laundering in kitchen sinks, exposing food preparation surfaces to the pesticides and fertilizers that workers are exposed to in the fields.[20] One worker commented, "If we go to a field, we can see cabins with eight or nine men living together, and these people have to cook and sleep in one single place ... do you think that makes us susceptible to illnesses or not?"[15]

In 1978 the deplorable state of migrant farmworker housing was blamed on insufficient monitoring by regulatory agencies. OSHA was the primary federal regulatory authority in charge of monitoring migrant farmworker housing, and was considered to be doing a poor job due to a lack of personnel and to confusion concerning its mission in regard to migrant farmworker housing.[2] Since that time, other agencies, most notably the Department of Labor Wage and Hour Division, have also assumed regulatory power over migrant farmworker housing, enforcing regulations more stringently and levying fines for substandard housing. Ironically, this has led to a deterioration rather than an improvement in standard of living for migrant farmworkers since the assessments of 1978.[4]

With stricter enforcement of standards regulating labor camps, many growers or camp operators are forced to choose between facing fines for violations, costs for renovations, or closing the camps. Many can afford no other option than to close the camps.[4] Jesus Tijerina, a crew leader, testified, "In the last year five camps in this area have closed. This means that more than 150 units have been closed. Usually in a unit you can have a family of five. The work has continued as before and the same amount of migrants keep coming back every year."[5] In areas where housing is only in use for part of the year, as is the case with most migrant farmworker housing, loan programs for farmworker housing (Sec. 514/516 Farm Labor Housing Program administered by the Farmers Home Administration) do not meet the needs of growers and operators. In the absence of some type of affordable financial assistance, most growers are unable to respond to the housing needs of the migrant farmworker population. It is estimated that fewer than 5,000 new units have been built since 1980.[6] Yet, since the end of the 1990 growing season, Colorado alone has witnessed the closing of almost 40 percent of its grower-provided housing units.[4] A Colorado vegetable grower told the National Advisory Council on Migrant Health, "Since a year ago it was my policy to burn all the houses down because there was no way that I could comply... This kind of pressure drives me against the wall and I wonder whether it is really worth ... caring for the human element."[7]

When migrant farmworkers cannot find lodging in labor camps they must seek it privately. In the rural areas where they work there is a shortage of available private housing, and private housing is not subject to federal regulation. The private housing that is made available to migrant workers tends to be substandard and relatively expensive. One worker noted, "Right now we are looking for apartments, and barely make [enough] to pay the rent. We pay $375 per month and they also want a deposit of $250 per apartment, $100 for gas, $50 for electricity. So you need $750 to get a house. It takes three weeks to make that much to pay the bills."[8] Frequently, the workers find themselves in worse dwellings than the camps which were closed, or with no dwelling at all. Yet the seasonal influx of population in these areas puts even this squalid housing at a premium. The only alternative to expensive, poor-quality shelters is living in a car or in the open.[4] One woman told the National Advisory Council on Migrant Health, "A lot of people live in the streets, or underneath a tree, underneath a bridge. Sometimes they even are staying there in the winters ... ."[16]

The migrant farmworker population is impoverished and comprised primarily of minority populations.[2] The U.S. Department of Labor reported in 1991 that seasonal agricultural workers received a median hourly wage of $4.85. However, these workers only worked about 34 weeks per year; fewer than half were covered by unemployment insurance, and fewer than one fourth had health insurance.[9] A family of eight working together all day may earn as little as fifty dollars or less.[10] Migrant farmworkers frequently meet resistance to their presence in private neighborhoods in the form of hostility or price gouging. In one case this year, seventeen individuals shared one run-down two-bedroom house, on which they were marginally able to afford the rent. At their current economic level, many migrant farm laborers will not be able to afford to continue working the crops in the absence of free or subsidized labor camps that have traditionally been provided by the grower.[4]

The phenomenon of migratory workers engaged in temporary work is no longer limited to rural areas. A new population of migratory temporary day laborers is being recognized in urban areas. In these cases, there are no traditions to support their presence and many communities are rejecting them whether they are seeking work or seeking shelter. In Orange county, California, it is found that frequently these individuals have no conventional shelter, but live in makeshift camps of cardboard, wood, and plastic hidden in canyons near towns. The county health department is routinely

called in to close and bulldoze the camps for sanitation violations. No alternative shelter is provided, and some citizens groups have gone so far as to attempt to limit funding for charitable organizations that offer aid to these workers. At the same time,it is acknowledged that there is a need for their labor.[11]

The deplorable state of housing for migrant workers is an accelerating crisis that will have a profound impact on both employers and workers with deep implications for the agricultural economy. Poor housing is rapidly becoming non-existent housing. Without decent, affordable housing, fewer workers will be able to make the seasonal work migrations, and those who do will face housing conditions worse than those of the previous decade for themselves and their families. Without the necessary seasonal labor provided by migrant farmworkers, growers will not be able to maintain their current rates of production, and will be less able to afford to provide and maintain adequate housing for the migrant farmworker population than they have been previously.[4] The Farmers Home Administration, Department of Housing and Urban Development, Department of Agriculture, and Department of Health and Human Services are in a position to significantly impact the migrant worker housing situation. If they coordinate their efforts and resources we may draw nearer to the time when safe and adequate housing will be available for our migrant workforce. Meanwhile, the migrant farmworker housing situation is caught in a downward spiral.

PROGRESS REPORT

As a result of the Advisory Council's prioritization of housing as the most important means of addressing farmworker health status, a working group called the National Hispanic Housing Council has been established. This work group has published a comprehensive set of recommendations, including a proposal for addressing the housing needs of farmworkers. The work of this group is significant in that knowledgeable experts have analyzed the need and proposed specific solutions.

"The most recent survey (1980) of the national need for migrant farmworker shelter indicates a shortage of nearly 800,000 units."[12] Consistent anecdotal evidence indicates that the shortfall is probably now much higher. Thus, the Advisory Council endorses the National Hispanic Housing Council's target of construction of not less than 10,000 units per year for the next ten years. According to feedback from HUD, Section 8 housing allowance subsidies available directly to families are not accessible to farmworkers because of their constant mobility. Just as the Medicaid program must be

held accountable for serving the eligible farmworker population, so must farmworkers be able to participate in housing benefits available to other low income Americans.

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APPROPRIATIONS/
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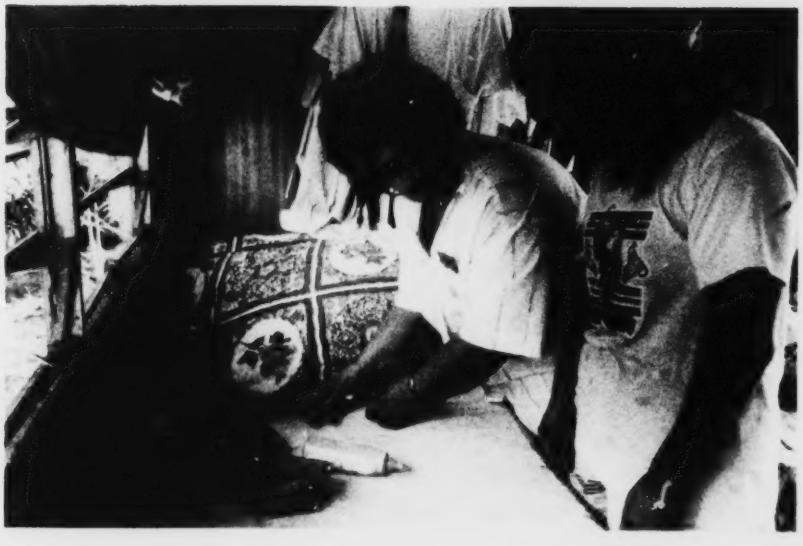

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APPROPRIATIONS/AUTHORIZATION

RECOMMENDATION: Current migrant health funding reflects an annual expenditure of approximately $100 per user per year, and a penetration rate of approximately 12 percent. If PHS 329 dollars are to be the primary source of health care for farmworkers, that appropriation must be increased in order to reflect a commitment of resources more in keeping with expenditures for other populations. The Council recommends an annual appropriation of $100 million for the Migrant Health Program and comprehensive perinatal care services for F.Y. 1994, with incremental increases thereafter, and requests the Secretary's support of this targeted increase.

During the late 1930s and early 1940s, the Farm Security Administration (later part of the U.S. Department of Agriculture) constructed Farm Security Camps at major points of farm labor demand. The camps provided housing, basic health care services, and referrals to cooperating physicians or hospitals. In 1946 the Department of Agriculture's farm labor program provided health care to more than 100,000 workers. This program was funded almost wholly by federal appropriations, and became a casualty in 1947 when Congress terminated all wartime emergency programs. One observer comments, "What Congress failed to note at the time was that the needs of seasonal farmworkers amounted to a continuing emergency that started before the war and lasted afterward."[1]

Change began slowly, primarily at the state level, in the 1950s, but conditions for farmworkers went almost unregulated by federal law until the passage of the Migrant Health Act. The Act, signed into law by President John F. Kennedy on September 25, 1962, established the authorization for delivery of primary and supplemental health services to migrant and seasonal farmworkers. Funded under Section 329 of the Public Health Services Act and administered by the U.S. Department of Health and Human Services, the Migrant Health Program has been a strategic partner in the delivery of health care services for thirty years. The Migrant Health Act was devised to make health care services accessible to migrant farmworkers and their families by helping states and local communities adapt their existing health care system to meet the unique needs of this population. The initial appropriation of $3 million was intended to pay for only part of the project costs; it was hoped that contributed funds from public and voluntary sources would be used to the fullest extent possible.

In the first year, 52 organizations were approved for Migrant Health Program support. According to the Senate Subcommittee on Mi-

gratory Labor in 1967, "The work is well begun... Still the need has not ended. Service coverage remains weak in many of the areas where projects are now receiving grant assistance. Three-fifths of the counties identified as migrant home-base or work areas are still untouched."[2] Grants under the Act in its first few years were generally small, and had to be supplemented with other resources. Beginning in 1965 and in subsequent years, "each time that the term of the legislation neared its expiration date, Congress extended the law and increased the annual authorization of funds. However, actual annual appropriations nearly always lagged behind the authorized level. Thus in 1983 the authorized ceiling was $47 million but the actual appropriation was $38 million."[1]

Today there are over one hundred migrant health projects whose clinic sites provide services to over 500,000 migrant and seasonal farmworkers and their families in 40 states and Puerto Rico.[3] In spite of this progress, the heavily-utilized services of existing projects are still able to serve less than fifteen percent of the estimated migrant and seasonal farmworker population in need. The misfortunes of the migrant worker are far-ranging, and are reflected in their overall poor health status. Migrant and seasonal farmworkers require a health care delivery system which offers effective, migrant-specific, culturally tailored health care.

Studies have shown that the migrant population is at greater risk and suffers more problems than the general population of the U.S. Since 1962, migrant health centers have struggled to serve the farmworkers who make up the backbone of this country's agricultural work force. However, the ongoing battle to provide services to this population is being lost.[4] A 1988 Report of the Labor and Human Resources Committee noted that:

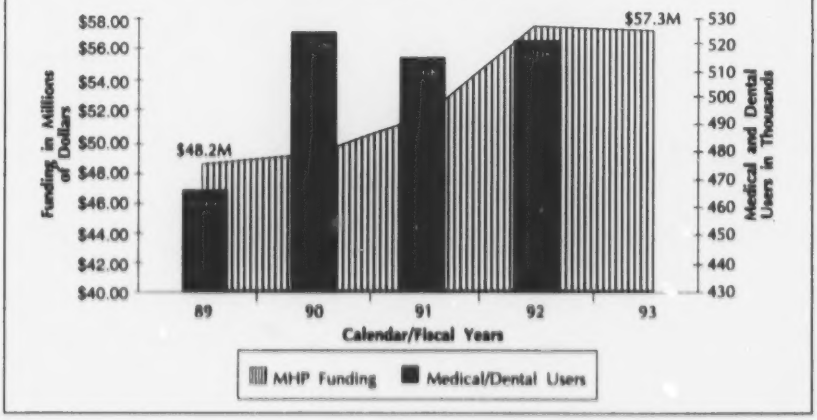
> *The Committee is aware that [case management] services—which were once an integral part of a typical health center's service package—are today offered by fewer than one-third of all C/MHCs. In most cases, these services were either reduced or eliminated due to funding constraints... [yet] these very services have been cited by numerous independent experts... as being particularly important in serving high-risk, hard-to-reach populations, such as ... migrant farmworkers and new immigrants...*
>
> *... it is the Committee's desire that, as additional funds are made available for these programs through future appropriations, priority should be given to the development or*

restoration of the patient case management services at existing health centers.[5]

As noted by the National Association of Community Health Centers, "Severe limitations on the federal budget in recent years have seriously affected [community and migrant health] center growth. Federal policy makers have attempted to aid centers in a number of ways... yet the demand for services far outpaces these small gains... . Yet the mere existence of health centers has been an aid to local economies. By stressing preventive care in the communities they serve, indigent reliance on hospital emergency rooms has been markedly reduced. Immunization and prenatal care rates are considerable higher among eligible C/MHC users than comparable community residents who do not use health centers."[6] Migrant health centers need the flexibility to utilize PHS 329 funds in implementation of service delivery models which are most effective for farmworkers, even if those models vary from the current "medical model." This includes the use of lay workers, perinatal outreach, special clinician recruitment projects, etc.

Rapidly escalating medical costs have made the funds available for farmworker health services less and less adequate. For example, "The 1984 migrant health appropriation was three times the amount in 1970. However, per capita health expenditures for the nation during the same period increased 3.5 times."[7] Figure 1 depicts the appropriation history for Migrant Health; if the program had kept pace with the consumer price index for medical costs, the current appropriation would be $87.9 million. The $100 million recommended appropriation includes this figure plus additional funding for comprehensive perinatal services for farmworkers.

FIGURE 1
Migrant Health Program Total Funding and Medical/Dental Users: 1989-1993



A 1985 report published by the National Migrant Worker Council aptly stated, "To expect a minimally funded Program to meet all the health needs of a deprived population in a time of high and rising costs is to expect the impossible ... At every level of operation, the Program generally lacks the funds and the staff required for full effectiveness in building and maintaining the kinds of coalitions with other public and voluntary groups that would bring the effectiveness and scope of service of grant-assisted projects to their maximum."[7] An example of the problems clinics face from funding shortfalls is demonstrated in the testimony of Jorge Miranda, a farmworker board member of a migrant health center. He described how his clinic had obtained a van, but could not pay for a driver to transport patients from the fields to the clinic.[11] The extent of farmworkers' unmet need for basic health care services is not only a national disgrace, but also a national challenge. In order to improve the overall health status of farmworkers in this country, a major appropriation increase for the Migrant Health Program is necessary.

In the late 1960s, Congress expressed the desire for the eventual expansion of programs for the general population to cover services to farmworkers. Congress noted, "However, for the foreseeable future ..., this program, because of its importance to the health of the American people, should be considered as a permanent and separately identifiable program... ."[8] By 1985, a new report indicated that, "Nationally, ... the Migrant Health Program serves as a nagging reminder of the continuing health problems of migrants... The separately identifiable health service program first envisioned by Congress ... seems as much needed today as it was in the beginning."[7]

The conclusion reported by the Public Health Service in 1954 remains pertinent today:

> *Migrants present the gamut of needs for health, education and welfare services—needs which are intensified by their economic and educational status and by the fact of their migrancy. Challenges to official and voluntary agencies lie in finding ways to coordinate required services locally and to make these services continuous as migrants move from place to place... At stake are the health and welfare of ... people who make a vital contribution to our national economy as well as to the health and welfare of the communities through which they move.*[9]

PROGRESS REPORT

The PHS 329 appropriations for FY 1991, 1992, and 1993 are as follows:

1991	$51.7 million
1992	$57.7 million
1993	$57.3 million

This represents an 11.6 percent increase from 1991 to 1992, and a 0.7 percent decrease from 1992 to 1993.

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MENTAL HEALTH

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MENTAL HEALTH

RECOMMENDATION: Farmworkers are desperately in need of access to mental health and family counseling services. They are less able to access existing community mental health services than many populations due to their constant mobility and the unavailability of culturally sensitive and bilingual mental health professionals. The Council recommends that the current state of crisis in the farmworker family be recognized by the Secretary, and opposes further programmatic cuts. Efforts must be initiated to fully integrate the mental health needs of farmworkers with the services of all federally-funded mental health programs. Special focus should be placed on expanded recruitment of minorities in mental health professions, recognition of peer counselors as an effective means of intervention, and service delivery collaboration between migrant health centers and the community mental health program.

Migrant farmworkers face enormous difficulty obtaining the basic necessities of life: food, shelter, and medical attention. They are poor, under-educated, subject to economic uncertainty and unsanitary living conditions. They frequently face prejudice and hostility in the communities where they stop to work.[1] Father Thomas More of the Colorado Migrant Rural Coalition testified that, "The migrant worker who comes [to Colorado] from Texas is... not allowed to speak up in matters which would require a change in legislation... . The people whose lives are affected... are not involved in the decision making."[2] The mobile nature of the farmworker family's occupation often precludes access to mainstream health care services. Their need for mental health services goes almost unaddressed, even though the harsh conditions under which they live has been correlated with an increased incidence of mental health problems.[1,3]

In his Children of Crisis series Robert Coles, a physician and child psychiatrist, characterizes the psychological pressures of growing up in the cycle of migrant farmwork: "How literally extraordinary, and in fact how extraordinarily cruel, their lives are: the constant mobility, the leave-takings and the fearful arrivals, the demanding work they often manage to do, the extreme hardship that goes with a meager (at best) income, the need always to gird oneself for the next slur, the next sharp rebuke, the next reminder that one is different and distinctly unwanted, except, naturally, for the work that has to be done in the fields." Dr. Coles continues,

> *There is ... the misery; and it cannot be denied its importance, because not only bodies but minds suffer out of hunger and untreated illness... Migrant parents and even*

> *migrant children do indeed become what some of their harshest and least forgiving critics call them: listless, apathetic, hard to understand, disorderly, subject to outbursts of self-injury and destructive violence toward others. It is no small thing ... when children grow up adrift the land, when the learn as a birthright the disorder and early sorrow that goes with peonage, with an unsettled, vagabond life.*[4]

Studies relate some of the stresses entailed by life in the migrant streams. A former migrant farmworker testified before the Department of Labor in 1974 to the conditions she had experienced while living and working in the migrant stream.[3] Due to low income, her family had no choice but to live in the labor camps provided by the growers. These camps were isolated, miles from towns and grocery stores. There were no recreational facilities or medical facilities. The houses had no heat or ventilation. Frequently there was no stove to cook on, and no place to store food where it was safe from vermin. The houses were over-crowded, and there was no privacy for such personal functions as bathing or using the toilet. Although her mother was a diabetic, the family had neither access to medical treatment for her nor means to purchase or prepare the kind of foods her condition required. Other studies recount the lack of privacy for adults for sexual relations[1] and long grueling hours of manual labor for low wages entailed by farm work, as well as the inherent health risks of farm labor (i.e., pesticide exposure and accidents).[1,3]

Economically the migrant farmworker is at the mercy of the weather. Rain or unseasonable weather can disrupt their work schedule and create economic havoc for them. In addition, migrant farmworkers tend overwhelmingly to be members of minority groups, with the majority being Hispanic. Although their labor is vital to the farming communities through which they work, migrant farmworkers frequently experience prejudice and hostility to their presence. Stress factors such as these have been strongly correlated with mental breakdown, self-destructive behaviors, and the need for mental health treatment.[1]

One farmworker recounted the pressure created by overcrowding: "There are very serious problems in families because a lot of times there are families ... [who] live four or five families in one place ... and a lot of times between families ... conflicts can arise ... And it's because of the poverty we're living in ... the lack of houses."[11] Another described the precarious existence of farmworkers, "I have

seen many of my friends going into the cabins as fugitives, so that the boss doesn't see that he is living with his friend, because there is nowhere [else] they can live."[12]

The stresses of the migrant farmwork situation are expressed both tangibly, through chronic health problems, and intangibly in emotional turmoil. Anxiety often takes the form of somatic symptoms such as headaches and neck pain.[1] Drug and alcohol abuse occur in high numbers.[5] Stress creates family situations that are often unstable, and sometimes abusive. Conflict erupts when children identify with the mainstream lifestyle and their parents enforce traditional values, fearing that their families will disintegrate.[1] Individuals with special problems are subject to further stress, as exemplified by the homosexual migrant farmworker who told an interviewer he had no one to talk to since he was sure his family would disown him if he revealed his secret to them.[6] The traditional solution to problems is for individuals to adapt to problems rather than attempt to change the circumstances that cause the problems. And so the problems are perpetuated.[1]

Delivering mental health services to the migrant farmworker community is not a simple matter. Migrant farmworkers are often unaware that services exist, so they do not seek them out.[7] The fact that farmworkers move so frequently makes it difficult for them to acquire care for chronic problems, and the physical barriers to delivery services are formidable. Most farmworkers are isolated geographically from clinics and care facilities; they frequently lack transportation and/or child care, and traditional clinic hours conflict with their work schedules and thus are prohibitive. But language and cultural barriers are two of the greatest deterrents to bringing necessary mental health services to migrant farmworkers.[3,7]

In addition, there is a critical lack of funding for farmworker-specific mental health efforts. One author states, "Mental health care for migrants has never been given consideration or time by the migrant [health] clinics or any other medical system in the United States."[7] Public mental health services in this country are funded primarily at the state level, with funds "flowing down" to provide services in local areas. While this method is adequate to serve stable populations, it does not meet the needs of a farmworker community which must be constantly moving by the very nature of its work. Funds are needed at the national level to develop outreach capabilities which will allow mental health services to be taken to the farmworker rather than vice versa.[7] A work group funded by the Office of Substance Abuse Prevention recently

recommended increasing appropriations for farmworker-specific mental health services at all levels, in addition to developing state and local strategies such as block grants, to address farmworker substance abuse prevention. The group also stressed the use of lay health workers and the integration of mental health and substance abuse services with migrant health clinics as mechanisms to improve access.[8] It is critical that the use of lay workers, which is effective with both families and single male workers, be accepted as an appropriate intervention strategy.

Mainstream Anglo culture does not look favorably on individuals who are poor, uneducated, transient, and ethnically distinct.[7] Migrant farmworkers are all of these things. The mainstream stereotype of the typical Hispanic is of a shiftless, dumb, illiterate, violent, drunk whose poverty is somehow indicative or moral turpitude.[1] Because they move frequently, disrupting their education, migrant farmworker children are often labeled "slow learners."[7] These negative appraisals are frequently incorporated into the self-image of the individual, resulting in low self esteem which is associated with a sense of powerlessness and depression.[1] It should not be surprising, then, that a mainstream clinic staffed with Anglo practitioners would be viewed as an alien and hostile environment, and not conducive to treatment that requires sympathy, trust, and understanding between practitioner and client.[3] For mental health intervention to be effective it cannot be only physically accessible, it must be culturally acceptable as well.

The mental health of an individual is composed of complexities of belief, thought, and emotion. Such concepts are often expressed in language by idioms, terms that are understood culturally but which literally may make no sense. Thus, when an Anglo practitioner listens to a young Hispanic woman telling him that she hears voices telling her to enter a convent, he may make a pathological diagnosis of auditory hallucinations with religious content when actually the woman is employing a figure of speech as harmless as saying she has a calling to the religious life.[1] If a practitioner lacks either the cultural or linguistic capability to detect such nuances, how is he or she to make an accurate diagnosis?[3] An example of the extremes such insensitivity can lead to is the 1966 finding that 30,000 Spanish-speaking Hispanic children in California had been placed in classes for the mentally retarded after being tested for mental capacity in English.[5]

Understanding the patient's language is necessary in order to deliver mental health services. But mere knowledge of language is

insufficient for comprehending the delicate shades of meaning that are expressed when people speak about their emotions. These shades of meaning can easily be lost or misconstrued through an interpreter or if the client must translate his or her thoughts into English before speaking. To truly understand what a patient is saying, the practitioner must understand the client's cultural background as well as language. For this reason, the migrant farmworker community would best be served by practitioners who are bicultural as well as bilingual.[1,3] As one rehabilitation coordinator commented, "[Mental health support groups] is a service that's provided to the Anglo community through mental health or private psychiatrists, but it is not provided for the farmworker. It's not even provided for the Hispanic population overall."[9]

Hispanic culture views illness differently from the way mainstream Anglo culture does. This is an important consideration because Hispanic members of the migrant farmworker population run the gamut from being fully immersed in mainstream American culture to being entirely traditional with no English-speaking capability. While the mainstream culture regards illness as an impersonal and blameless event, the result of germs or fate, the traditional Hispanic culture regards illness and health as being connected to harmony between the natural and the supernatural. Thus, an individual's illness reflects on his or her relationship with the community and with God, and a system of folk medicine has developed to restore harmony to the body and the spirit when these relationships somehow become unbalanced.[1,3] In order to be able to treat individuals who believe in this value system, it is necessary to understand what they believe about their own condition. It is also necessary to determine if the patient is reporting all problems or dividing treatment between conventional and folk practitioners. If the practitioner is not well versed in Hispanic culture and is ethnocentric and judgmental, the patient is likely to be alienated and uncommunicative. But even if the practitioner is sympathetic, it is not going to help to communicate on delicate and complex issues if he or she literally does not speak the same language as the client.[3]

In order to provide mental health services to Hispanic migrant farmworkers there must be compatibility between patients and practitioners in matters of language and culture. Staffing migrant health care facilities with bilingual and bicultural practitioners would be a pragmatic step in that direction. It is important for practitioners to be aware of what is considered polite and appropriate as their relationships with their clients progress. These concepts are expressed in the Spanish language, which a formal

and an informal form of address. The latter is used between friends and intimates, but is insulting or patronizing if used with new acquaintances. If a practitioner initiates treatment by accidentally insulting the client it is doubtful that there is going to be a favorable prognosis.[1] Likewise, it is important for the practitioner to understanding the stage of acculturation of the client. A client from a traditional background who is determined to acculturate is subject to numerous stresses associated with rejecting the culture he was raised in while simultaneously being cut off from the support system that culture provided. An individual who retains traditional beliefs may experience culture-specific illness such as "mal ojo" or evil eye which will not disappear with ridicule, but must be addressed respectfully. To function in this scenario, a practitioner must be culturally enlightened.[1]

Bilingual, bicultural programs have been implemented successfully through medical clinics. The Camp Health Aide program in Michigan, which was implemented primarily as a medical outreach program to migrant labor camps, found that migrant farmworker volunteer camp health aides experienced an increased sense of self esteem and empowerment.[10] La Clínica del Cariño in Hood River, Oregon experienced such success with a lay health advisor/promotora program that recruited farmworker women as health aides that they developed a mental health program called La Familia Sana. The La Familia Sana outreach program conducts culturally competent mental health and substance abuse education for farmworker women and adolescents.[13] Family Health/La Clínica in Washington State established "Las Comadres," a gathering place for migrant farmworker women who were depressed and cut off by migration from the feminine support network they had at home. The resulting access to peer support yielded favorable results.[1] It has also been suggested that establishing mental health resources for migrant farmworkers in proximity to primary care clinics could help alleviate the stigma associated with seeking mental health services as well as reducing transportation barriers.[1]

The migrant farmworker population is subject to pressures which greatly increase their risk of suffering from some form of mental illness. Their mobility complicates the difficulties involved in providing mental health care for them with the problem of how to provide continuity of care to a transient population. The linguistic and cultural background make it necessary for programs which deliver services to them to also be bilingual and bicultural or risk being ineffective. Relevant mental health services are simply not available in sufficient quantity to even begin to meet the need.

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FAMILY ISSUES

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FAMILY ISSUES

RECOMMENDATION: The Council strongly recommends that all special projects which are designed to strengthen the family include a specific farmworker component in order to assure relevancy to the migrant family. The Council recognizes women to be the central core of farmworker families, and requests that the Secretary's focus upon women and families be expanded to include farmworker women. Special consideration should be made within HHS at the national and state levels to integrate Migrant Health and Migrant Day Care through prioritization of funding for joint service delivery models. More daycare facilities need to be established in farmworker labor camps and communities. The council requests that the Secretary address this as a first step in meeting the needs of migrant families.

The harsh realities of life in the migrant stream include poverty, hard manual labor, unsanitary living conditions,[1] lack of medical insurance or access to care facilities,[2] high rates of illness, early death, economic uncertainty, and personal humiliation.[3,4] The same issues which affect migrant farmworkers as individuals impact them as families as well. According to the Department of Labor, the majority of seasonal agricultural workers are married and/or have children. Two in five of these workers live away from their families while doing farm work.[5] For single male workers who must leave their families behind as they migrate in search of work, social isolation and lack of recreational outlets takes it toll. When asked how he felt about being alone, one worker responded simply, "It is very ugly."[6] Many other migrant farmworkers travel as family units, whether they do so independently in extended family groups or under the control of a crew leader.[1]

Farmworker children have difficulty remaining in school. Flora Martinez testified before the National Advisory Council on Migrant Health, "Young field workers are dropping out of school again because they have to help their parents, they have to be able to sustain their family ... ."[23] Women labor all day in the fields and bear the full responsibility for domestic labor when the official work day is over.[7] The results of living under such conditions are poor physical health, strained personal and family relationships,[3] increased incidence of child abuse, and an even greater incidence of unintentional child neglect.[1,8,9] In all senses, the well-being of migrant farmworker families is jeopardized by the conditions of their existence.

The general toll their lifestyle takes on the health of migrant farm laborers is well documented. The incidence of pathological con-

ditions may vary by over 175 percent from one source to another. What is agreed on, however, is that migrant farmworkers suffer higher rates of tuberculosis, intestinal parasitic infection, skin diseases, influenza, pneumonia, gastrointestinal diseases, and skin diseases than the national average.[1,4,10] They are also at high risk for accidents and pesticide exposure.[3,10] Their irregular income leaves them prey to malnutrition.[11] Their mobility makes it difficult for them to access health care for chronic complaints or any condition which requires continuous care. Pregnant women often do not receive adequate prenatal care, and children are not usually taken for medical care unless they are displaying symptoms.[12] One study determined the life expectancy of migrant laborers to be 49 years, compared to the national average of 73 years.[1] The national infant mortality rate is 14 out of 1,000, while a 1989 study found the infant mortality rate among California migrant farmworkers is 30 out of 1,000 and the mortality rate for migrant farmworker children up to the age of five is 46 out of 1,000.[13] Examination of children on one study revealed that a large number had conditions requiring treatment which were asymptomatic.[14] Another study revealed that migrant farmworker children were not achieving the average height for their ages, were vitamin-deficient, and showed many other symptoms of malnutrition even though they had the proper proportion of subcutaneous fat for their size.[11]

Migrant laborers often are living by survival economics, and are geographically isolated from treatment centers. Money, time off required from work, and lack of transportation, combined with linguistic and cultural disparity are the most effective barriers to health treatment which migrant workers face.[12] Most migrant farmworkers have only a fifth- or sixth-grade education,[12] and many do not speak English as their first language.[5,15] These factors make it difficult for the migrant farmworker to recognize and be able to communicate the details of health problems to caregivers when they manage to reach a health care facility.[4] As stated in a 1991 report on farmworker health status, "Whatever the reason for not visiting health clinics, the outcomes are clear—multiple morbidities representing a population with poor health status that may need significantly greater care and more treatment due to the delay in receiving initial care."[10]

A study conducted by Public Voice in 1989 found that 50 percent of the migrant farmworkers surveyed had diets that did not meet the Recommended Daily Allowance for vitamin A, iron, or calcium. Almost a third reported running out of food or not having enough food at some time during the last year. As many as 25

percent suffered from intestinal parasites, with the highest infection rates being among children. Yet fewer then 25 percent participated in the Food Stamp program because of misconceptions which led them to believe they were ineligible.[16] Other studies found that migrant farmworkers bought the foods that they could afford to buy in the order of: meat, milk, sweets, fruits, and vegetables. If they could not afford to buy from all these groups, they cut them out of the food budget in reverse order. The children of these families were found to be vitamin-deficient and suffered from disorders induced by malnutrition.[11]

Women in the migrant farmworker population often receive little or no prenatal care during their pregnancies. Many pregnant farmworker women fall into high risk groups due to being younger than eighteen or older than 35. Lack of money, lack of transportation, and lack of child care are all cited as reasons for not seeking prenatal care, as well as not perceiving a need for it.[12,17] Many cannot afford care. As Maria Aloray testified to the National Advisory Council on Migrant Health, "Many of these women, 85% of these women do not have medical cards, they don't have private insurance, they don't have a way to pay for prenatal care."[24] Most pregnancies are unplanned and many women do not use any form of birth control, although many of the women interviewed expressed a wish that they had not become pregnant. One study found that the incidence of miscarriage and infant mortality dropped among a group of pregnant women who had received birth control options. The inferences was that mothers with desired pregnancies were more motivated to seek health care for themselves and their infants than mothers with undesired pregnancies. The need for prenatal care in the migrant farmworker population is reflected in a high incidence of miscarriage, infant mortality, and complications of pregnancy, including vaginal and urinary tract infections, anemia, and sexually transmitted diseases.[17]

The social implications of the conditions under which migrant farmworkers live are as dire as the physical ones. One women who fled from domestic violence with her baby described the situation she ran from. She and her husband and infant had shared one-room quarters with five single men. Over time her husband became increasingly violent and unpredictable. He began to beat her and the baby, and she was unable to predict what would initiate a violent episode. She fled after one of the men living with them also began battering her. She attributed her husband's behavior to a reaction to being "pushed around so much," and speculated that "being treated like a slave is harder for men to accept."[4]

The circumstances of the migrant lifestyle—overcrowding, poverty, lack of sanitary living facilities or recreation, and lack of dignity—place great personal strain on individuals which can be reflected in their personal lives.[3] Some individuals and families working under the auspices of a crew leader have no personal control of their finances. If the crew leader is exploitative they often find themselves indebted and virtually indentured to the crew leader.[4] This lack of control over their lives increases the stress on individuals that the migrant lifestyle entails.[3]

A study conducted in New York State found that the risk of child abuse or neglect was six times higher among migrant farmworker families than the national average. Although there was incidence of intentional abuse, most of the 497 allegations listed entailed involuntary neglect, such as 175 allegations of inadequate guardianship; 67 of lack of supervision; 62 of lack of food, shelter, and clothing; 19 of educational neglect; 16 of lack of medical care; and 4 of alcohol or drug use by a child. The tendency toward abuse/neglect was found to be higher in single-parent families, and women were more likely than men to be the perpetrators.[8] A finding by the East Coast Head Start program that there was a higher-than-average incidence of abuse/neglect allegations among migrant farmworkers in the vicinity led to inception of an educational program geared to lower that number. Three years after implementation of the program the incidence of abuse/neglect allegations among the local migrant farmworker population fell by 56 percent, to a number under the national average.[9] The inference of research is that education, day care, and effective social service delivery are the answer to the problem of child abuse and neglect among migrant farmworker families and that, in most cases, families are providing the best care that their precarious economic existence allows.[1]

The center of the migrant farmworker family is the mother. Although men are usually perceived as the primary wage earners, as many as 70 percent of the women work in the fields with their husbands. Although she may share the field work, the women is traditionally considered solely responsible for home and child care as well. This is a staggering burden considering the heavy nature of farm labor. It is also staggering to realize that 63 percent of the migrant farmworker population is estimated to consist of children 16 years of age or younger who require care. The problem of child care is a serious one, and frequently mothers have no choice but to take their children to the fields with them or to leave them unattended.[7,18] A retired farmworker told the National Advisory Council on Migrant Health, "In my case I was always working all the time. Sometimes it gets really cold. We [didn't] have enough

clothes or food. I didn't want to take my children to work, but I had to take them with me."[19]

That women are anxious to improve the hazardous conditions under which their families live is evidenced by the successes of such programs as the Camp Health Aide program in Michigan and the Salud Clinic Outreach program in Oregon.[20,21] In the Camp Health Aide program, female migrant farmworker volunteers were trained to disseminate health and social service information in the labor camps where they lived.[20] During educational sessions conducted by the Salud Clinic, eager women were taught basic concepts of hygiene to cut the spread of intestinal parasites and other diseases. The women explained that they were not unwilling to implement the concepts of good hygiene (in spite of the difficulty of doing so in labor camp housing conditions), but that the connection between hygiene and the spread of disease had never been demonstrated to them before.[21] Farmworker women have also been effective participants in movements to improve wage and working conditions in the migrant community.[7]

A farmworker commented, "I believe we have the right to live in a decent way. We are the labor force. It's like we are foreigners—I am a U.S. citizen. Farmworkers come here with hope but go home worse off than before."[22] Migrant farmworkers work long hours for low wages. They live and work under substandard conditions that frequently pose a hazard to their health and the health of their children. Poverty often causes them to lack proper food and needed health care. The strains in their lives sometimes result in domestic abuse. Their lack of education often leaves them in ignorance of what they can do to help themselves. Experience has shown that migrant farmworkers are willing to adopt measures that will improve the lives of their families, once the means of doing so are shown to them. Migrant farmworker families are a population at risk whose needs should be remembered in any programs geared to aid families.

PROGRESS REPORT

Progress in 1992 includes the development of an interagency Memorandum of Agreement (MOA) between the Migrant Head Start Program and the Migrant Health Program. The development of this written document included interaction between representatives of both programs at both the field and policy levels. The MOA will be implemented at the direct service delivery and national levels.

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HEALTH
REFORM

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HEALTH REFORM

RECOMMENDATION: The Council recognizes that managed care and managed competition are potentially effective cost control measures, but is concerned that these measures could create even greater barriers for farmworkers. The Secretary must assure that farmworkers are not left out of any health care reform strategies. The Council recommends that the Secretary support a program which would standardize eligibility criteria from state to state, provide portable benefits, and annualize income, thus eliminating barriers to enrollment of farmworkers. Any new reform in the current system must not exempt farmworkers and agricultural employers from required protections currently available to other workers. It is essential that the current level of primary care services available to farmworkers not be reduced, and consideration of additional measures should include reciprocity of Medicaid; national health insurance; a national migrant health alliance (Health Insurance Purchasing Cooperative, or HIPC); provisions for mental health care; supplemental services such as transportation, case management, and outreach; and expansion of primary services to the entire population. At current levels only 12 percent are served.

The exact composition of the migrant farmworker population is not known; however, its numbers are estimated to fall between three and five million.[1] Thirty-eight percent of this population consists of women and children under the age of fourteen.[2] The average annual migrant farmworker family income is substantially lower than the national poverty threshold, and migrant farmworkers experience more health problems than the general population. The Secretary must assure that the unique issues facing farmworkers are embodied in the development of a national health care reform package. Health care reform must recognize the mobility of these workers and the need for a portable benefits package as they move from state to state.

Migrant farmworkers precisely fit the profile of the population the Medicaid program was designed to protect, and it was anticipated that the Medicaid program would increase access to basic health care for farmworkers. However this has not been the case. As a group, migrant farmworkers have more difficulty accessing the benefits of the Medicaid program than any other population in the nation.[1] The current administration's focus on health reform raises the question of the likelihood of farmworker participation in any other state-based model which might be designed to provide medical coverage to the poor and low income people of this country. For the purposes of this statement, we will analyze the current Medicaid model and the barriers to farmworker participation. Without adequate consideration, the barriers presented by the Medicaid system could well be carried forward to any reformed system.

The Medicaid system was designed to form a "safety net" for the lowest-income members of society.[1] It was meant to insure that impoverished citizens, especially pregnant women and children, had access to adequate health care. The Medicaid program is federally mandated, but is administered by individual states with both federal and state contributions. The federal government has provided broad guidelines for the program, but these guidelines are open to interpretation by individual states, and the process of administering the Medicaid program is not uniform between states.[3]

Regretfully, participation of eligible farmworkers is impeded by the state-based structure of the Medicaid system, and by eligibility requirements which are not uniform and benefits which are not portable. That this critical labor force should be excluded from the national safety net as a result of the mobility required by their employment is outrageous. Much discussion is currently taking place about health reform and managed care. It is critical for the Secretary to assure that the needs of the farm labor force are included in the design of health reform legislation. All indicators point to the probability of any new programs being state-based, as is the current Medicaid program, with health alliances serving as collective purchasing agents. It is also likely that the most basic benefit package offered under any reform system will comprise the maximum care that farmworkers will have access to. Farmworkers, therefore, need an enhanced set of basic benefits that travel with them. I.e., access to this set of benefits must be universal and must supercede varying state structures if it is to affect the health status of migrant and seasonal farmworkers. Analysis and elimination of the barriers which currently exist is important in the design of farmworker participation, and will be useful in the adoption of health reform. Failure to do so constitutes perpetuation of a system which discriminates against a sub-population on the basis of employment and minority status.

Migrant farmworkers make their living by working the peak seasons of agriculture. This entails moving frequently to obtain hard labor at low wages, living in sub-standard housing conditions, and exposure to numerous health hazards.[4] Many migrant farm laboring families travel as a unit, with as many family members working as possible. Each state in the union utilizes the labor of migrant farmworkers. It is not uncommon for a migrant farm laborer to spend less than a month in one locality.[1] This fact alone accounts for one of the greatest obstacles migrant farmworkers face when they attempt to access the Medicaid system.

The law allows migrant farmworkers to apply for Medicaid in whichever state they are working.[1] However, states are allowed forty-five days to process an applicant's eligibility forms. By the time this process is complete, many migrant farmworkers have had to move on to the next job, which will frequently be in another state.[2] Once a worker's eligibility for the program is established, it must still be re-validated every one to six months, depending on the state and the eligibility category.[1]

Almost half of the nation's migrant farmworkers have less than a ninth-grade education. Many of them do not speak English as their primary language (although they were born in the United States), and most states provide application forms in English only.[2] Frequently, migrant farmworkers lack transportation to the appropriate office; this difficulty is compounded in states which require multiple visits to complete the application process. And coming to an office during traditional office hours, the hours maintained by most state agencies, means the loss of a day's wages or even the loss of employment to migrant laborers.[1] There are no provisions to streamline this process even for pregnant women and infants, a group for whom Medicaid benefits were recently expanded.[2]

The need of farmworkers for health benefits is great. The infant mortality rate among migrant farmworkers is 25 percent higher than that of the general population.[2,5] Migrant farmworkers are subject to more accidents, dental disease, mental health and substance abuse problems, and as a population suffer a higher incidence of malnutrition than any other sub-population in the country. They also experience high rates of diabetes, hypertension, tuberculosis, anemia, and parasitic infections,[6] while their low income levels make private health care prohibitive. The health status of migrant women is particularly disturbing. Migrant farmworkers tend not to apply for benefits until they are already experiencing a need for health care services. The government has established migrant health care clinics, but there are so few of them in relation to the numbers of migrant farmworkers that they serve less than fifteen percent of their targeted population.[1] Also, migrant laborers who are employed may be ineligible for Medicaid benefits by virtue of their seasonally fluctuating employment.[2]

Migrant workers need and, in most cases, qualify for the benefits that Medicaid would afford, but their greatest obstacle to obtaining them is completing the application process. If a farmworker does manage to navigate the system and obtain Medicaid benefits, he or she must reapply for them when moving into another state. If

the worker cannot be located when it is time to re-certify eligibility for benefits, the benefits lapse.[2]

The law does allow states to reciprocate on Medicaid benefit eligibility, but the administration of the system is not uniform among states. When one state honors another state's Medicaid eligibility for a recipient, the paperwork tangle involved in billing for the services may cost more than the value of the medical services rendered. If the patient must be contacted in order to complete paperwork and that patient is a migrant farm laborer, it may not be possible to locate him. These circumstances do not encourage states to make an effort to accommodate the need of migrant farmworkers to be enrolled in the Medicaid system.[1]

Providers may also be reluctant to accept farmworker Medicaid patients. Farmworker Jorge Miranda described his experiences: "I got a [Medicaid] card from the state for my children. The medical card is not accepted in a lot of clinics ... sometimes they don't want to attend us even if I pay cash ... And I asked, 'Why don't you attend me,' because my son ... had bleeding from his umbilical cord ... and they told me that they couldn't take care of me because I had the [Medicaid] card."[9] The current system for the distribution of health benefits is not generally accessible to migrant farmworkers, although they are among the most needy members of our population. Migrant farmworkers face frustrations when they try to access the system, and states face frustrations when they attempt to cooperate to serve the migrant population.[1] Meanwhile, farmworkers suffer from a host of preventable and treatable diseases which Medicaid would cover, but for which they are unable to obtain treatment.[2] Preventive care is cheaper than catastrophic care, but under the current system most farmworkers do not have that option. A nationally administered program to provide health care to migrant farmworkers could bypass the problems the individually administered state programs are currently generating.

The same barriers that prevent farmworkers from accessing Medicaid will have to be addressed under any health reform system if farmworkers are to be included. The health care reforms currently being considered cannot be applied to mobile populations like migrant farmworkers unless these barriers are removed. The goal of the Council is to insist that universal coverage be provided to all farmworkers and their families. Implicit in that goal is the need to maintain and expand the infrastructure of migrant and community health centers, which have traditionally provided accessible, culturally competent health care to the farmworker population. The implementation period for universal coverage to include farm-

workers will require provision of supplemental benefits, such as transportation, translation services, case management, and other services necessary for culturally diverse, under-served populations like migrant and seasonal farmworkers.

If health reform follows the concepts outlined under managed competition, the National Advisory Council on Migrant Health believes that a specific national migrant health alliance or HIPC must be structured for migrant farmworkers and their families. National administration of the Farmworker Health Alliance will be necessary in order to avoid the breakdown of services for this mobile population which has been demonstrated under state administered programs like Medicaid. The nationally administered Farmworker Health Alliance would manage the health benefits for migrant farmworkers with a standard benefit package, uniform eligibility and enrollment procedures, reimbursement arrangements, etc. Farmworker benefits must be portable; they must be able to access their benefits wherever in the country they travel. Such a program would insure that farmworkers receive and keep national access to high quality care. In essence, it would mean the creation of a national migrant health passport.

Any strategy designed to provide universal coverage must be cognizant of the need for a national strategy to expand the number of primary care providers willing to work in under-served communities throughout the country. Without an adequate supply of primary care providers, universal coverage will not guarantee access to care. The National Health Service Corps is an excellent vehicle to boost the number of providers available to under-served areas.

There will continue to be bitter battles among government officials, health care providers, consumers, and special interest groups in the months ahead as the culture of medicine and the health care delivery system in this nation change. Migrant and seasonal farmworkers have suffered from the neglect of the current system of American health care. The failures of the past must not be repeated. The needs of farmworkers must be recognized in the health reform debate and addressed in the new models of health care delivery.

PROGRESS REPORT

Progress in 1992 includes the development and publication of a Request for Proposal (RFP) to conduct a feasibility study of Medicaid interstate reciprocity. Responses to the RFP have been submitted, and a contract will be issued in the second quarter of 1993. Although the current health reform movement is exploring options

to Medicaid, the results of the study will be applicable to any state-based system reform.

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OUTREACH

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OUTREACH

RECOMMENDATION: Farmworkers, by the nature of their work and lifestyle, are an extremely hard-to-reach population. Conventional strategies to provide health care services have been less than effective. The Council recommends that the Secretary designate resources to expand community outreach services to farmworkers. All new federal initiatives should include a migrant component and a special allocation for this population, thereby making health care more available, accessible, and acceptable.. Use of both clinical and lay health workers has been proven to be an effective and appropriate means of providing services to migrant farmworkers.

The need of migrant farmworkers for medical attention is well documented, and federally-subsidized migrant health clinics exist, but statistics show that less than fifteen percent of the target care population is able to access their services.[1] This is believed to be due to the fact that the clinics are located, due to financial constraints, in cluster areas where large numbers of migrant farmworkers will congregate for peak agricultural work seasons. Unfortunately, this by no means insures geographical proximity to a clinic for the majority of farmworkers.[2] Even when affordable health care facilities are available, migrant farmworkers experience greater difficulties accessing them than the mainstream population.

The population of migrant farmworkers as a group are poor, uneducated, frequently isolated, and chronically under-employed. Statistically they suffer from an array of health problems for which treatments are available, but to which they lack access.[2] A number of farmworkers testified before the National Advisory Council on Migrant Health that they were simply not aware that services were available. One said, "We follow the harvest from California to Colorado. I am not aware of aid or help. We don't know how to get it."[3]

In North Carolina, 67 percent of migrant farmworker families interviewed were able to subsist on their income but were not able to meet emergencies. Twenty-five percent were not able to subsist on their income or meet emergencies. Twenty-two percent were living in unstable relationships, six percent were living in abusive relationships, and ten percent showed evidence of child abuse or neglect. Thirteen percent of the children in this group showed evidence of stunted growth, which is thought to be an indication of poor nutrition, possible recurrent infections, and intestinal parasites. Twenty-four percent of the children suffered from anemia, and another 24 percent from diarrhea.[4]

A recent survey found that multiple and complex health problems existed among over 40 percent of all farmworkers who visited migrant health clinics.[5] As a group, migrant farmworkers experience a life span that is approximately 30 percent shorter than the national average, and an infant mortality rate that 25 percent higher than the national average.[6,7] The need of migrant farmworkers for health and social services is obvious, but a number of facts account for their difficulty in obtaining necessary health care.

The migrant farmworker population is comprised of a number of races and ethnicities, with the majority being Hispanic. Many individuals do not speak English as their primary language, and thus experience difficulty when they attempt to acquire medical attention or apply for social services.[8,9] Migrant farmworkers frequently lack transportation and cannot get from the job site to a clinic. Their physical and linguistic isolation may leave them unaware that services they need are even available.[2] Conventional business hours are also prohibitive to migrant farmworkers who need health care. Many cannot afford to lose a day's wages in order to come to a clinic or office during traditional business hours, and so forego care.[10] One farmworker explained what was needed this way: "What I would like [to have is] more clinic time on Saturday and Sundays if people are working. A lot of times people get sick on Saturday or Sundays and there are no clinics open. They would need to be open at 9:00 at night [too]. That's the time when one gets through working. One doesn't know when they're going to be sick, and one needs a doctor when they're sick."[18] Services are often divided between agencies or institutions, thus compounding the difficulties that migrant farm laborers experience with time, transportation, and translation when they seek care.[2]

In response to the difficulty that migrant farmworkers experience trying to access the system, outreach programs have been developed which attempt to take services to the migrant farmworkers. In order to implement outreach programs it has been found necessary to assess the composition of the local migrant farmworker population in order to address their specific needs. The federal Migrant Health Program defines outreach as making services known to the population and insuring that they can access all the services which are available. Outreach programs, according to the Migrant Health Program, should improve utilization of health services, improve effectiveness of health services, provide comprehensive health services, be accessible, be acceptable, and be appropriate to the population being served.[2] These guidelines recognize the demographic and cultural diversity that is encoun-

tered within the migrant farmworker population and the flexibility that is required to connect the workers with the services.

The demographic nature of the migrant farmworker population varies with location. The migration routes followed by migrant farmworkers are referred to as migratory streams. The home state is usually in the south and is referred to as downstream, while the work states are upstream. The three predominant streams are the east coast, midwest, and west coast streams.[1] A study in Oregon, a state in the western stream, found that the migrant population there was overwhelmingly Hispanic,[10] while in North Carolina the population was found to have a majority composition of Hispanics, but also to contain Blacks, Haitian and other Caribbean immigrants, Whites, and Native Americans.[11] While the Oregon program could reach its target group by having staff who were bilingual in English and Spanish, the North Carolina program needed trilingual speakers of Creole as well as Spanish and English in order to communicate with their target group. In order to be effective, outreach programs must be appropriate to their unique circumstances.

Three significant outreach programs developed in three different states are using varying means to successfully reach migrant populations that were previously isolated from necessary health and social services. Although there are numerous other outreach programs in place at both the local and state levels, the designs of these three have been thoroughly documented and will serve for discussion purposes. In North Carolina, the Department of Maternal and Child Health of the School of Public Health at the University of North Carolina at Chapel Hill initiated an outreach plan in conjunction with the Tri-County Community Health Center (TCCHC), a federally-funded migrant health clinic. This program utilized the services of lay health advisors recruited from the migrant farm labor camps to disseminate health information and identify individuals in need of health services.[11] The Farm Labor Camp Outreach Project implemented through Salud Medical Center in Oregon uses a van to take medical services and educational materials to migrant labor camps.[10] The Midwest Migrant Health Information Office in Michigan administers a state and privately-funded program which trains individuals from the migrant labor camps as camp health aides.[12]

The Maternal and Child Health Migrant Project, administered in North Carolina through TCCHC, focused on assessment of the health and nutritional status of pregnant women and children, and on means of improving their condition. It also set out to develop model protocols and a data collection and reporting system to assist

migrant health center staffs in the management of high-risk mothers and children, to design and implement systems linking available resources for migrant farmworkers, to demonstrate the effectiveness of lay health advisors in disseminating accurate, culturally appropriate health information to the migrant farmworker population, and to develop educational modules based on the realities of migrant life to be used by migrant health care delivery services.[11]

The clinic staff found the major barriers to accessing health care among migrant workers to be lack of transportation, inability to speak English, and a lack of access to child care. The clinic responded initially by hiring staff who were bilingual in English and Spanish, and later also in English and Creole. The clinic utilized a bus to transport migrant farmworkers to appointments, but found this to be insufficient and implemented the services of volunteers to aid in transportation also. The project coordinated the services of the local county health department, social service agencies, local hospitals, Migrant Head Start center, and WIC, thus helping to connect the migrant farmworker with the necessary social service with the least amount of inconvenience. The center's maternal health nurse arranged for bilingual clinic staff to assist with deliveries in local hospitals in exchange for systematic referral of TCCHC patients for postpartum care. This improved the working relationship between the hospitals and the center, and increased the center's notification of patient deliveries. Recognizing a flow in the migrant stream between North Carolina and Florida, the center also made contacts in Florida to establish a tracking system for TCCHC patients. In order to overcome the language and cultural barriers to seeking health care within the migrant farmworker population, the concept of lay health advisors was developed.[11]

The goals of the lay health advisor training program were to instill an "everymother" knowledge of general maternal and child health issues and community resources in the participants, as well as the display of an affirming, non-judgmental attitude in their role of helper; for helpers to be able to share effectively with their peers; and for helpers to be able to follow a problem-solving methodology.[13] To this end the program recruited women from the migrant labor camps who had a reputation of leadership ability, peer respect, attitudes of empathy or caring, interest in learning about their health and the health of their children, and an understanding of the importance of sharing that knowledge with family and friends.[14] They were given fourteen hours of training on their role as advisors, child growth and development, infant and child nutrition, diarrhea and dehydration, safety and environment, family violence and community resources, and dental health. The advisors were tested on these subjects before and after training, show-

ing a significant increase in their post-training knowledge. One lay health advisor recognized the symptoms of meningitis in her own child immediately after training on the subject.[15] Lay health advisors reporting having several contacts a week in the camps with people who needed advice about seeking treatment. They referred pregnant women to the center, identified and requested assistance for cases of spouse abuse, and in one case identified the need for follow-up treatment on a post-surgical case.[11] Psychological tests showed lay health advisors scoring higher than other migrant farmworker women in terms of self efficacy, development of a positive social identity, measures of collective empowerment, and the ability to conceptualize appropriate action in specific situations. The lay health advisors themselves attributed these results to their experiences with the program.[16] Statistical data does not show a significant change in the incidence of specific disease rates in the camps where lay health advisors operate,[17] but anecdotal evidence shows that their presence is having a positive impact on the migrant labor camps they operate in.[11] Also, the influence of lay health advisors does not end when they move on to the next migrant labor camp. In this way the influence of the TCCHC program is extended beyond its sphere of immediate influence through the eastern migratory stream, and migrant farmworkers are enabled to take measures to help themselves.

The Farm Labor Camp Outreach Project at the Salud Clinic took the clinic to the workers. A medical van was outfitted with necessary supplies to conduct on-site medical screening tests and educational programs. Bilingual staff were hired to spare workers the embarrassment of discussing their health problems through a translator. The visits to the migrant labor camps were coordinated, with the help of the growers, to coincide with peak crop seasons in order to reach the greatest number of workers possible, and visits were made after work hours in order not to conflict with work schedules. The clinic itself remained open until 8:00 p.m. twice a week to accommodate migrant farmworkers' work schedules. Workers were screened for hypertension and anemia, and educational sessions were conducted on sexually transmitted diseases, AIDS, pesticides, nutrition, hygiene, parasites, anemia, diabetes, hypertension, immigration, substance abuse, and tuberculosis. The van also carried referral forms for medical treatment and applications for WIC. If patients were found to need treatment, appointments and transportation were scheduled for them. Preventive information on disease was provided and eagerly received.[10]

The Midwest Migrant Health Information Office (MMHIO) camp health aide program was developed by the federal government in

conjunction with the Catholic Consortium for Migrant Health Funding to establish a model program which individual states would then be encouraged to take over. In this case, the State of Michigan has assumed full responsibility for the program within its borders. Camp health aides are recruited much the same way as the lay health advisors in the North Carolina study, with similar goals and outcomes. The presence of the camp health aides has helped to overcome the language barrier, prejudice, and long work hours that prevent many migrant farmworkers from gaining the medical information and attention they need.[12] Camp health aides and lay health advisors are members of the migrant population themselves, and remain identified with their culture in the eyes of their peers. Their example reinforces the idea that preventive health care has value, while the information they provide encourages their contacts to assume control of their own health care rather than depending on outside intervention.[13,14] MMHIO is now working to extend its outreach work to the downstream home bases of migrant farmworkers.[17] The Office of Migrant Health has issued *Community Outreach Guidance: A Strategy for Reaching Migrant and Seasonal Farmworkers*, which details the diversity of outreach programs, and considerations in implementing them.[19]

Outreach programs range from taking services to the target population to training the target population to serve itself. In all cases they serve to bring people and services together which otherwise would not connect. The migrant farmworker population is particularly vulnerable, needing aid yet frequently lacking the means of access or even of communication with the sources of aid that exist to help them. Outreach programs are effective means of consolidating the fragmented social services that frequently frustrate the attempts of migrant farmworkers to seek aid. Properly administered, outreach programs can serve not only to gain access to resources for migrant farmworkers, but also can guide them toward self-sufficiency.

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OCCUPATIONAL AND ENVIRONMENTAL HEALTH

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OCCUPATIONAL/ENVIRONMENTAL HEALTH

RECOMMENDATION: Farmworkers suffer the highest work related injury, morbidity, and mortality rate in the nation. Agriculture is consistently listed as one of the three most dangerous occupations in the nation. The Council recommends that the Secretary establish an interagency group with the Department of Labor, the Occupational Safety and Health Administration, the Environmental Protection Agency, and the Social Security Administration. This group should consult with the Advisory Council to address the enforcement of regulations and laws protecting farmworker health and safety (e.g., workers compensation, disability qualification, pesticide exposure, adult and child labor, and field sanitation). Farmworker input is especially crucial to the success of the recently issued EPA worker protection standards. The interagency group should be charged with the responsibility to identify and implement joint solutions to assure that farmworkers are able to participate in the programs operated by these agencies, and that legislative and regulatory loopholes which exempt agricultural workers from basic protections available to other workers are eliminated.

When evaluating health risks, occupational and environmental exposure are usually classified as two separate categories. In the case of agricultural workers, however, it is difficult to draw a distinction between the two. Therefore, for the purpose of addressing the types of exposures which farmworkers risk, the two are linked together in this background statement. If both factors were placed on a spectrum, the range of environmental and occupational risks might appear as follows:

1. Exposure to the elements: sun, rain, dust and pollen, and freezing temperatures.

2. Exposure to natural toxins and allergens in fruits and vegetables such as strawberries.

3. Exposure to a wide range of chemicals which are used in all stages of agricultural production.[3]

4. Illness and disease caused by impure water sources, improper disposal of sewage, infestations of rodents and insects, and substandard, crowded, and/or inadequate housing.[6]

5. Lack of toilets, potable water, and hand washing facilities in the work place.

6. Social dysfunction due to overcrowding in labor camps (i.e., substance abuse, child abuse, domestic violence, sexually transmitted diseases).

7. Educational disruption due to constant mobility and urgency of work.

8. Working conditions which hinder the employee's ability to observe good health practices and/or comply with a specified medical regimen.

9. Constant stoop labor.

10. Ladder accidents.

11. Accidents involving large and small farm equipment.

12. Hazards for children in the fields.

13. Highway accidents to families in migration due to poor equipment or drowsiness.[3]

14. Inability to qualify for basic health and disability benefits such as Workmen's Compensation or Social Security due to negligible status.[2,3]

Corresponding to this spectrum, one would find a range of symptoms and illnesses among workers that would encompass dehydration, viral infections, frostbite, minor headaches, gastrointestinal disorders, dermatitis, severe depression, chronic migraines, musculoskeletal problems, miscarriage, birth defects, cancer, loss of eyesight, loss of limb, social disfranchisement, loss of work and wages, and ultimately, loss of life.

Reducing environmental and occupational risks for farmworkers requires the full involvement of all organizations with responsibility for agricultural laborers. The Department of Health and Human Services, the Social Security Administration, the Department of Labor, the Department of Justice, the Department of Housing and Urban Development, the Farmers Home Administration, the Occupational Safety and Health Administration, and Civil Rights must all be responsible for and responsive to the needs of farmworkers. The Council's recommendation that the Secretary combine forces with these entities to improve conditions for farmworkers is essential because it will take a combined effort to challenge the status quo.

Basic worker protection standards which were enacted in the early part of this century exempt agricultural workers. Loopholes which discriminate against farmworkers are in fact based more on the economics of the agricultural industry than on the well-being of the worker. More recently, field sanitation (1987) and environmental (1992) worker protection standards have been promulgated to cover agricultural workers; however, the standards themselves have weaknesses and are nearly impossible to enforce.

Farms with fewer than eleven workers are exempt from field sanitation laws. In 1990, OSHA conducted field inspections and found that 69 percent of farms that were subject to the law were in violation. In 1989 the Department of Labor was able to inspect only 1.5 percent of workplaces covered by the Fair Labor Standards Act. The loopholes in the law and the deficiencies in enforcement led the General Accounting Office to conclude in 1992 that farmworkers are not adequately protected by federal laws.[2]

The lack of such basic requirements for farmworkers as access to potable water and toilet facilities has been linked to high rates of communicable diseases. Dr. Jesse Ortiz participated in OSHA's hearings on field sanitation for farmworkers in 1984. He reported that farmworkers are at 20 times greater risk of parasitic infection than the general population, 11 times greater risk of contracting gastroenteritis and infectious diarrhea, and 300 times more likely to develop infectious hepatitis.[9] Farmworkers have also been found to be 3 to 5 times more likely to develop urinary tract infections due to the lack of toilets and drinking water.[3]

When workers are injured on the job or disabled after years of repeated exposure, only limited numbers qualify for Worker's Compensation or disability benefits.[2,3] The single most effective achievement on behalf of this population would be the assurance that they receive the same protections available to an industrial worker.

PESTICIDE EXPOSURE

Pesticide exposure results in both acute and chronic effects. The effect of acute poisoning is widely recognized; however, little is understood about the long term effects of repeated low level exposure. Ezequiel Morfín describes his situation: "... the chemicals are affecting the community a lot, and there are no studies that have been done over a long period of time. I've been a field worker and I've worked with chemicals. And they produce long-term allergies, and they cause colds that last two or three years to get rid of [sic]. We believe [it is] because of the chemicals ... when I go

to the places where they have used chemicals, right away I break out. And so I have been contaminated."[11] Some studies reveal multi-generational effects of pesticide exposure among farmworkers and their families. Of significant note are the clusters of cancer and birth defects which have been documented in the Earlimart and McFarland, California.

The Environmental Protection Agency (EPA) estimates that 300,000 farmworkers suffer acute illnesses and injuries as a result of pesticide exposure annually.[3] Lack of effective testing methods to verify exposure as the cause of a symptom means that physicians are not able to rule out other possible causes. Heavy reliance on the use of pesticides and fungicides in the agricultural industry supports the volume production of inexpensive, blemish-free food which the consumer has come to demand. Those who benefit most from the economic results of the use of pesticides are less likely to suffer from the impact of exposure.

The EPA published the final rule on worker protection standards and hazard communication for agricultural workers on August 21, 1992. "EPA has taken a three-pronged approach to protecting farmworkers from pesticides on the job. Provisions in the new rule will attempt to prevent exposure to pesticides, mitigate exposures that do occur, and inform employees about the hazards of the pesticides they work with."[4]

Under this new rule, employers are required to provide training to all workers within 16 days after an employee begins work. Training must be documented and repeated once every five years, or when a new hazard is introduced into the workplace. Exemptions to certain aspects of this rule (e.g., reentry intervals) have already been granted to the cut flower and fern industry on the basis of their request citing economic hardship. Other requests for exemptions may be forthcoming.[5]

Testimony from farmworkers at public hearings repeatedly underscored the fact that knowledge of what has been applied and of required reentry intervals is helpful information, but that farmworkers are not able to sacrifice their jobs and must do what they are told when they are told in order to feed their families and preserve shelter. Estevan Sanchez testified before the National Advisory Council on Migrant Health, "We have seen that the farmers don't take the measures that should be taken as far as the spraying because ... they spray in one field and they will bring it right next to us to work. So it's not very far away from the spray. And a lot of times they would have to wait four or five days so that the strength

of the spray [would diminish] and other times they don't wait that long because they need to do the work. And so they decide to have the people go to the work as it is."[12] In order to effectively implement measures to protect farmworkers, it is necessary to get farmworker input and determine the context of the situation they must contend with. Failure to do so will result in inappropriate programs that are inadequate to accomplish the goal of worker protection.

WORKING CONDITIONS

It is interesting to note why agriculture has traditionally been exempted from occupational protection standards. The evolution of worker protection arises out of the industrial movement in the United States. The regulation of age and working hours for children, the reduction of dangers created by equipment or closely confined working areas, ventilation of sweatshops, and unionization were all important achievements in the industrial revolution. By contrast, the small family farm as a workplace was seen to be a mecca of fresh air and "God's green earth."

Then as now, however, working conditions included beginning work before dawn in the damp mists of early morning, stoop labor, long hours in wet clothing, and exposure to rain, freezing temperatures, and high temperatures. These conditions result in respiratory and viral problems, dehydration, and chronic poor health.

The demise of the small family farm and the rise of large agribusiness has only served to intensify the exposure of large numbers of workers to such risks. It is common knowledge that farmwork is now the most dangerous occupation in this country, more dangerous even than mining and construction. Although agricultural workers account for only 3 percent of the work force, they account for 14 percent of work-related deaths.[1]

HOUSING

As reflected in the recommendation and background statement on this subject, housing is the most critical issue for farmworkers. Failure to mention this issue within any discussion of environmental/occupational risks would be inappropriate. The farmworker housing where it exists is substandard and exposes occupants to physical injury, sanitation-related diseases, and increased risk for infectious diseases, parasites, tuberculosis, and a host of other preventable disorders. One farmworker testified to the National Advisory Council on Migrant Health that cabins are sometimes located within the fields, where farmworkers cannot see notices posted by the grower regarding pesticide applications.[13]

For more information on housing issues, please refer to the Housing recommendation and background statement.

MIGRATION

Migration itself needs to be considered in any review of occupational risk factors. Such risk factors are elusive in that they are nearly impossible to document, yet professionals who work with farmworkers on a regular basis are highly familiar with the impact of migration on the individual lives of farmworkers and their families. The seriousness of this impact is frequently diminished by myths perpetuated by the general public: "Farmworkers like to travel—they are like gypsies," "They are used to these conditions, why they're better off here than they are at home," "It's just a summer vacation for them—they get to travel across the country and earn extra spending money on top of their regular jobs," "It's like going camping." The reality is that farmworkers are just like any other humans, with need for stability, continuity, privacy, and security in their lives.

The impact of constant migration over the span of a child's early developmental years can be very negative. In addition to the actual physical risks involved in constant traveling of the highways, like breakdowns, accidents, and being stranded because of lack of funds, there are also psychosocial risks related to hunger, long hours of work, crowding, homelessness, lack of ability to establish friendships and relationships, the stress of travel and poverty on their parents, and academic interruptions. Even if a family manages to provide a secure environment in spite of the occupational necessity of traveling, often exposure to the dysfunction of other migrant families has a serious impact.[7]

Although the majority of farmworkers travel as a family unit, there are also large numbers of single males who leave their families in order to support them. These males, far from their homes, are vulnerable to exploitation by unscrupulous crew leaders and locals who would involve them in the sale and use of drugs and alcohol and prostitution.[8]

CONCLUSION

The economic and political forces which combine to perpetuate the status quo for farmworkers are beyond the control of the workers themselves. The environmental and occupational exposures they face daily are so closely intertwined that they cannot be looked at as separate entities. In a presentation to the Surgeon General's Conference on Agricultural Safety and Health, Dr. William Popendorf stated, "Adverse health effects are the culmination of an often complex chain of events beginning with the agent

emanating into the working environment from a sometimes nebulous source and traveling through a physical pathway to create [health problems]." Certainly the spectrum described herein is a complex chain of events. Dr. Popendorf also cites the paradigm of anticipation, recognition, evaluation, and control. It is truly through the application of each of these steps that occupational and environmental risks for farmworkers can be effectively reduced.

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HEALTH PROFESSIONS

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HEALTH PROFESSIONS

RECOMMENDATION: It is critical that solutions for health professions training for migrant and community health centers be multi-disciplinary and both short and long range in nature. By this we mean that efforts should focus not only upon physicians, but also upon nurses, dentists, hygienists, environmentalists, social workers, nutritionists, etc., since the delivery of care to migrant populations requires a team approach. Solutions to yield immediate results for the health professional shortage must be put in place, as well as long range solutions. Specifically, the Council recommends that the Secretary implement programs which will:

Collaborate with Migrant Education and Department of Labor programs to train migrant youth in allied and clinical health professions.

Expand loan repayment programs to include the full range of health professionals, especially nurses.

Require health professional schools to recruit minority students into the health professions.

Increase the number of registered nurses in rural areas.

Encourage advancement of clinic farmworker staff, and the integration of farmworkers into health professions.

Provide incentives for health professions training programs to offer more opportunities for training in migrant health programs, including formal linkages with these programs.

Increase recruitment and retention of minority, Spanish-speaking, and/or culturally sensitive health professionals.

Place emphasis upon training and placement of dental professionals.

Address the current acute problem in recruitment and retention by appropriation of dollars to enable migrant health centers to offer competitive salaries.

Establish creative, effective ways for health centers to provide incentive packages which improve retention of providers in all health professions.

Consider allocation of specific levels of National Health Service Corps dollars for loans and scholarships to be incorporated into funding for migrant health centers.

It is no exaggeration to say that the health status of migrant farmworkers is in a state of crisis.[1] Health care facilities with bilingual, bicultural staffs have implemented successful inter-disciplinary programs to cover the wide range of health and health-related social service needs of migrant farmworkers.[2] However, with 103 federally-funded migrant health center grantees nationwide, there are still too few of these facilities with too few qualified practitioners to staff them effectively to serve a target population estimated to number up to five million.[3,4] Domatila Tavera testified before the National Advisory Council on Migrant Health that, "What is needed [is] more doctors, more people who can provide ... assistance to those people. Those who have diabetes and tuberculosis, cancer, and different kinds of sicknesses or illnesses ... the young women that are alone here and are pregnant expecting their first baby, they need a lot of help from all the clinics."[14] Another woman testified that it was not uncommon to wait for hours, even with an appointment, and finally be told that the doctor would not be able to see everyone that day.[15]

That the approach to delivery of migrant health care services should be inter-disciplinary and creative is demonstrated by the broad range of problems from which migrant farmworkers suffer. They need services for physical illness, mental health disorders, and dental care. There is also a demonstrated need for preventive services such as nutritional counseling, family planning information, and basic education about health issues, hygiene, and well child care.[3] Farmworkers are frequently unaware of programs that exist to benefit them, and need to be linked with the appropriate social service agencies that provide aid. Workers face many obstacles to gaining access to service facilities, chiefly lack of time, money, and transportation and linguistic and cultural disparity with clinic staff.[2]

Programs that have successfully overcome these problems have done so with unconventional methods, significant outreach components to their programs, and a team approach to solving problems.[2] Examples of these programs include the Salud Clinic in Oregon,[5] Tri-County Community Health Center in North Carolina,[6] and the Niagara County Migrant Health Clinic in New York State.[7] All of these clinics employ bilingual and bicultural staff. They engage in significant outreach programs aimed at the migrant farmworker community, and enable that community access them.

All of these clinics see clients outside of traditional business hours. Without this consideration, many migrant farmworkers would not be able to keep an appointment. Transportation is provided from the labor camps to the clinics, and also to referral appointments. The clinics serve as social service clearinghouses, coordinating services with appropriate social service agencies and frequently helping clients to translate and fill out forms.[5,6,7]

Evening clinics, translation services, transportation of clients, and social service coordination are not part of the traditional medical milieu, but they are essential services for the migrant farmworker community.[7] Successful programs require dedicated, competent staff from a broad range of health professions, preferable with bilingual ability and bicultural backgrounds. These individuals must be willing to coordinate their efforts and go beyond the boundaries of traditional health care services in order to care for their clients. Health professionals serving the migrant farmworker population have greater demands placed upon them than practitioners in traditional medical settings.[2]

Unfortunately, the typical migrant health center is unable to pay wages that are competitive with standard health care facilities in order to attract and keep staff.[8] Migrant health clinics were dealt a blow in the recruitment of physicians by the downsizing of the National Health Service Corps (NHSC). In 1987, 50 percent of the physicians in migrant health centers were serving out NHSC terms of two, three, or four years. With the expiration of those terms NHSC physicians had no obligation to remain at the clinics.[3] (It should be noted that the revitalization of the NHSC scholarship program currently underway will have an enormous positive impact on recruitment of migrant health providers. The National Advisory Council on Migrant Health wholeheartedly supports efforts toward this revitalization.) The average longevity of all medical staff at migrant health centers is between three and four years.[3,8] Migrant health centers also face another disadvantage because their Public Health Service Act section 329/330 grant support prohibits them from using grant money for student loan assumption, which is an attractive recruitment incentive.[3] To be effective migrant health clinics make unusual demands of their staffs, but they are financially crippled in their ability to recruit and retain staff.

One affordable and effective means of staff recruitment is participation in preceptorship programs, which place medical and other health professional students in clinics where they practice under supervision. These programs provide staffing power for migrant

health clinics now, and promote migrant health centers as an attractive career option to participants later. The mutually beneficial nature of this option makes it one that should be aggressively promoted and pursued. Participation in these programs has resulted in better staff retention in the clinics, and enthusiasm on the part of the students for primary care and for entering community health practice.[3,9,10] Most of the existing programs are for physicians in training, but small programs to place physician assistants are also being developed.[11] Collaborative training efforts and internships should be expanded to include the whole range of health care providers, including dentists, optometrists, mental health professionals, nurse practitioners, nurse midwives, and physician assistants.

The unique demands of migrant health service reveal a need for bilingual and bicultural staff.[2] The migrant health centers also require a broad of staff, including nurses, nurse practitioners, nutritionists, mental health counselors, dentists, and social workers in addition to physicians.[3] Since the clinics are unable to compete with mainstream salaries, they need to be able to offer other incentives for recruitment, and they need to be able to offer those incentives to all types of providers, not just physicians.[3,9] One way to do this would be to allow migrant health clinics to assume student loans for staff members, and to allow them do to this for all health professions rather than for physicians only.[3] Also, the success of programs like the lay health advisor program indicates that the migrant community itself is a good source of capable, bilingual, bicultural, motivated personnel for training and subsequent employment in the field of migrant health.[6] Involvement of migrant students early in their education, before the dropout rate reduces their numbers drastically, could be an effective method to tap this resource, especially if loans, grants, and/or other incentives were developed for students who finished high school and pursued careers in the health professions. Since many students leave school to work, mentoring programs which paid a stipend for summer jobs in health centers would provide a means for students to stay in school.

Migrant farmworkers desperately need access to health care, and migrant health clinics need qualified, motivated staff in order to deliver health care services.[3] Lacking parity of wages with mainstream clinics, incentive programs must be implemented in order to inspire qualified health professionals to seek employment in migrant health care.[9] Recruitment to primary care service in under-served areas is most successful among health professionals who either come from under-served areas themselves, including minorities, or whose training included some exposure to primary care settings for under-served populations.[12,13]

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RESEARCH

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RESEARCH

RECOMMENDATION: Anecdotal information has highlighted various aspects of the hardships of migrant health and lifestyle. However, the lack of national research and hard data on migrant and seasonal farmworkers has hindered the efforts of clinicians, administrators, policy makers, and researchers to effectively make changes and establish priorities for migrant health. Specifically, estimates of the size of the migrant and seasonal farmworker population vary widely. Basic health status indicators such as age-related death rates are unknown. Prevalence rates of the most common causes of death in the U.S. have yet to be studied. The Council recommends that the Secretary make an overall commitment on behalf of the Department to obtain health status indicators on farmworkers by sex and age by 1994, and on various farmworker sub-populations by 1998. This will require the commitment of non-service delivery funds to conduct research, assess effective intervention strategies, and evaluate policy impact. The Council recommends that the Secretary identify research dollars already allocated by Congress to be dedicated to migrant research efforts, and that every effort be made to secure resources from Agency for Health Care Policy and Research, the National Institute of Health, and Centers for Disease Control and Protection for the same purpose.

The available information regarding migrant farmworkers in America generates as many questions as it does answers. Who are migrant farmworkers? How many of them are there? Where do they come from? What is the state of their health? What are their living conditions? These are questions to which the current literature offers conflicting and piecemeal answers. Current, comprehensive, nationwide studies of the migrant farmworker population are lacking.[1] Much of the research on migrant farmworkers is seriously out of date, having been done in the 60s and 70s.[2] It is generally acknowledged that census figures are not reliable indicators of the actual numbers of migrant farmworkers,[1] and the tabulation methods of other agencies that count migrant farmworkers result in widely varying totals.

Regional information reveals the migrant farmworker population to be at high risk for health problems and frequently to be in distress.[3] While studies at the local, state, and stream levels may be useful for planning in specific areas, these studies "... have limited applicability to the wider farmworker population. Yet not infrequently, the results of these studies are used to represent the farmworker population at large."[4] But migrant farmworkers are a mobile population with a shifting composition, and we lack the documentation to accurately assess the needs of the migrant farmworker population as a whole.[1] Because the health problems of migrant farmworkers are inter-related with the other details of their lives, health studies frequently provide background information on

the group of farmworkers being observed. But these studies tend to be local or regional in nature, and thus are not representative of the total migrant population.[1] As of 1986, the only national reporting system to track health data among the migrant farmworker population was the Migrant Student Record Transfer System, which tracks the health and academic records of students. No program exists to track this information among the adult population.[1]

Many different government agencies have attempted to number the migrant farmworker population, including the Census Bureau, the Department of Labor, the Migrant Health Program, and the Department of Agriculture. The results of these studies place the migrant farmworker population anywhere between 159,000[5] and five million.[6] The huge discrepancy in these totals is due to the utilization of different counting methods and differing criteria on who is considered a migrant farmworker by the agency.[5] The census count of migrant farmworkers is considered unreliable because it is collected in April and categorizes an individual's employment according to the job they held most recently within the last two-week period. The census is conducted before most agricultural activities employing migrant farmworkers have gotten underway for the year. So, the job that a migrant worker will have held in the last two weeks before the census may not reflect his or her employment for a significant part of the year as a migrant farmworker.[1] Other agencies may count workers, but will not include their dependents who travel with them and are subjected to the same living conditions and health hazards as the workers. Different agencies also adopt varying standards in determining what constitutes migrant farm work. The fact that migrant farmworkers are a transient population increases the difficulty of counting them accurately.[5]

Also a factor in the comparison of statistics across agencies is the lack of a standard definition of terms. Former Vice Chair of the National Advisory Council on Migrant Health Charlene Galarneau explains, "In the farmworker health context, this assumed migrant difference [from other populations] has also come to characterize seasonal farmworkers. Initially authorized to serve migrant farmworkers and their family members, [the federal Migrant Health Program's] 1970 reauthorization contained an expansion of its service population to include seasonal farmworkers and their family members."[4] The Migrant Health Program's program data, therefore, includes data on the combined migrant and seasonal populations. Other programs may report data on migrant or seasonal workers only, or may have definitions of "migrant" and "seasonal" which differ significantly from the definition used by the Migrant Health Program. Finally, "Farmworkers are a diverse population... In the absence of adequate information, farmworker

health care services planning, delivery, and evaluation is necessarily based on weak generalizations and assumptions about farmworker health care needs. Such generalizations provide little guidance in the prioritization of needs and in resource allocation. These generalizations and assumptions are often made in the language of difference which obscures farmworker diversity and gives us the impression of having greater knowledge about farmworker health than we actually have."[4]

The composition of the migrant farmworker population is also difficult to determine. The ethnic composition of this population fluctuates and is now predominantly Hispanic, but also includes Blacks, Native Americans, Creoles, Asians, and Whites. The same factors which make it difficult to count migrant farmworkers also make it difficult to precisely categorize them ethnically or to accurately determine their downstream point of origin. But all of these factors can influence an individual's health status and ability to access the health care system.[1] For example, if a clinic can be reasonably sure that there will be no Creole speakers in their client population, there is no need to allocate funds to recruit Creole-speaking staff to that particular clinic. Conversely, if that same clinic incorrectly anticipates having no Creole clients and then gets a significant number of them, the clinic will not be prepared to effectively deliver health care services to them. A clinic must know who its clients will be and have some background knowledge about their problems to be able to effectively allocate its resources.[1]

Statistics on the incidence of disease in the migrant farmworker population reflect vast discrepancies. The Interstate Migrant Education Task Force stated in a 1979 publication that the death rate among migrant farmworkers from influenza and pneumonia was twenty percent higher than that of the average population, and that the death rate from tuberculosis was 25 times higher.[3] An article about migrant farmworkers published in 1978 stated that the death rate among farmworkers from influenza and pneumonia was 200 percent higher than the national average, while the death rate from tuberculosis was 250 percent higher.[7] Both of these publications refer to "migrant farmworkers." We do not know the source of the information in either publication; we do not know if these figures were misquoted by one party or the other, or if in different parts of the country both sets of figures might be correct. The introduction to the Interstate Migrant Education Task Force publication quotes the President's Commission on Mental Health that, "... much of the data frequently quoted in reports on the health needs of migrant farmworkers is suspect, and there is a lamentable tendency to pass along such data from one report to another without current documentation as to its validity..."[3]

Similar studies conducted by separate agencies in different migrant streams may produce different results. However, there is usually insufficient data on the populations being studied, or on the study methodology itself, to accurately determine what variables produce the conflicting results.[8] The data from local and regional studies is usually insufficient to justify extending the findings to the whole migrant farmworker population.[5] However, "We need not make another common assumption, that it is impossible to obtain reliable health data on farmworkers. A significant population-wide effort has not yet been made."[4]

Two separate studies on the health and mortality of migrant farmworker children were conducted in North Carolina and Wisconsin.[9,10] The North Carolina study found an infant mortality rate among migrant farmworker children of 30 deaths out of 1,000.[9] The Wisconsin study discovered an infant mortality rate of 29 out of 1,000, but also revealed that 45 out of 1,000 migrant farmworker children die by the age of two, and 46 out of 1,000 die by the age of five.[10] The national infant mortality rate was cited by both studies as 14 out of 1,000. The North Carolina study does not track the infant mortality rate of migrant farmworker children past infancy, so we do not know how children in North Carolina fare after infancy compared to the migrant farmworker children in Wisconsin. Neither of these studies indicates what the conditions actually are for migrant farmworker children across the nation.

The Wisconsin study cited difficulties in the assessment of mortality and health statistics among migrant farmworkers. Vital registrations such as birth certificates did not list the occupation or ethnicity of parents, so the information could not be compiled from registrations. The demographic data from the National Center for Health Statistics also failed to identify migrant farmworkers, and so could not be used for migrant studies.[10] Other sources cite problems in ascertaining death rates among the migrant farmworker population since no states list migrant status on death certificates.[5] The difficulty in obtaining migrant statistics from registrations makes it necessary to obtain them through surveys.[10] This method of data collection is complicated by the fact that many migrant farmworkers are fearful of dealing with officials.[1] These factors make it difficult to scientifically determine whether migrant farmworkers suffer from the same health problems as other impoverished populations or if there are migrant-specific ailments brought about by their working and living conditions.[5]

A 1990 analysis of data collected from migrant health centers in the midwestern migratory stream by the Migrant Clinicians Net-

work provides the broadest picture to date of farmworker health status. The study clearly indicates that the migrant farmworker population is at greater risk and suffers more problems than the general population in the U.S. The study's author notes, "Factors such as poverty, malnutrition, infectious and parasitic diseases, poor education, a young population, and poor housing equate to a highly vulnerable population in need of resources... The need for developing a health policy and research agenda for migrant farmworkers in this decade is evident."[11] A review of literature published between 1966 and 1989 pertaining to the health of migrant farmworkers was conducted by George S. Rust, MD. He determined that the health status of migrant farmworkers has not been well measured. According to Dr. Rust's assessment, questions regarding migrant farmworker health remain unanswered on the following issues: population characteristics, mortality and survival data, perinatal outcome data, chronic disease data, occupational risk, nutritional factors, health-related behaviors, and accessibility to health care.[5]

Most cancer epidemiological research in agriculture is focused on owner/operators. Preliminary research of the National Cancer Institute (NCI) indicates that farmworkers suffer an excess of cancers of the buccal cavity, pharynx, lung and liver. Again the lack of data is cited. NCI indicates that cohort studies of farmworkers are needed to gather cancer information. Such studies would require identifying a cohort of farmworkers for which historical medical records are available, due to the relatively long latency period for cancer which needs to be investigated. The difficulty in conducting such studies will lie in tracking the mobile patient cohort being observed. NCI recommends identifying a patient cohort of farmworkers with historical medical records, investigation of farmworker cancer among children (including in utero), and developing a series of questionnaires for use in screening farmworker patients for inclusion in a research cohort.[13]

Many regional and local studies have been conducted on migrant health issues, and on a local scale they are useful. But the limited scope of these studies makes them questionable as indicators of the health status of the migrant farmworker population as a whole. To date, most of the information comes from clinic-based research, which is time-consuming and costly and still leaves the major questions regarding the health status of migrant farmworkers nationwide unanswered. One thing which does become apparent from clinic-based research is that the primary care function of the clinics is desperately needed by their client populations. Clinics need their limited resources for primary care, and should not have

to make their funding do double duty for both treatment and research.[1] One migrant health project representative stated, "There is tremendous value if we can really document how the health needs are greater for migrant farmworkers... There is also tremendous potential for generating more funding if we can show how we're having an impact on the health of these people... It takes funding to do that. [But] then we get into the bind that if we've got inadequate funding, how do we support the research agenda without sacrificing patient care?"[12]

Accurate information on the migrant farmworker population is required in order to efficiently allocate the resources available to serve their health care needs. This information is also necessary to determine exactly what those needs are at present and to anticipate future needs. Currently, our information on the migrant farmworker population is fragmented, conflicting, and frequently out of date. Research should be both population and practice based in nature, and should be conducted with dollars which are not re-directed from service delivery appropriations.

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